DOCUMENT RESUME

ED 274 751 UD 025 157

AUTHOR Weatherley, Richard A.; And Others
TITLE Patchwork Programs: Comprehensive Services for Pregnant and Parenting Adolescents. Monograph No. 4.
INSTITUTION Washington Univ., Seattle. Center for Social Welfare Research.
SPONS AGENCY Public Health Service (DHHS), Rockville, Md.
PUB DATE Sep 85
GRANT APR-000908-02-0
NOTE 268p.
AVAILABLE FROM Center for Social Welfare Research, School of Social Work, University of Washington, Seattle, WA 98185 ($11.00).
PUB TYPE Books (010) -- Reports - Research/Technical (143)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Adolescents; Child Rearing; Community Cooperation; *Community Health Services; *Community Programs; *Early Parenthood; Pregnancy; *Pregnant Students; *State Programs; Youth Problems; Youth Programs

ABSTRACT

Adolescent pregnancy first emerged as a major social problem in the late 1960s and early 1970s. Among the responses to this problem was the promotion at the national, State, and local levels of an intervention model linking education, social, and health services for pregnant and parenting teenagers. This study addresses: (1) how and why local programs for pregnant and parenting adolescents have been developed and maintained, and (2) what accounts for the development and maintenance of comprehensive programs in some communities and not in others that appear equally or more needy. Four states were selected for study: Massachusetts, Michigan, California, and Tennessee. Within each state a pair of localities were chosen (two in California) making a total of five pairs matched according to socioeconomic and demographic characteristics. Each pair included one locality with a comprehensive program and one without. Programs were evaluated according to the following criteria: (1) leadership, (2) knowledge of alternative program models, (3) State funds, (4) policies and technical assistance, (5) advocacy group and interest group activities, and (6) State and local political culture. After an overview describing the purpose and design of the study, including a definition of the term "comprehensive," State and local case studies are presented for each of the ten localities. Finally, the book addresses the concept and constraints of comprehensive services, discusses conditions and strategies for successful program initiation and maintenance, and offers recommendations. (LHW)

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Patchwork Programs: Comprehensive Services for Pregnant and Parenting Adolescents

Richard A. Weatherley,
Sylvia B. Perlman, Michael
Levine and Lorraine V. Klerman

Monograph No. 4

Copies of this monograph are available from:

Center for Social Welfare Research
School of Social Work
University of Washington
Seattle, Washington 98195

September 1985

This research was conducted under a grant from the U.S. Public Health Service, Office of Population Affairs, grant number APR 000908-02-0. The authors are solely responsible for the findings and conclusions.

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ISSN 0883-7643
ISBN 0-935035-01-X

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ACKNOWLEDGEMENTS

Many individuals helped with this study. We are particularly grateful for the enthusiastic support and cooperation of the state and local service providers, administrators and planners without whose help the study would not have been possible. Michael Lipsky, Deborah Klein Walker, and Judith Gorbach gave us advice about the study design and selection of the sites. Virginia Cartoof, who was conducting her own research on the Massachusetts parental consent law, was a valuable consultant throughout the study. We also wish to thank David Hawkins and the anonymous reviewers at the University of Washington Center for Social Welfare Research for their helpful comments.

The research was initiated at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, and completed at the Center for Social Welfare Research, School of Social Work, University of Washington. We wish to thank Stuart Altman, Dean of the Heller School, for his encouragement; Joel Cohen and Barbara Wakefield for help with the financial management; and our project secretaries, Lynn Grady Ronci and Diane Hines for their unflagging assistance with the many logistical details of the project. At the University of Washington School of Social Work, Dean Scott Briar, Research Center Director David Hawkins, Mary McMahon-Schwartz, Elissa Clothier, Elsie Faires and Denise Lishner facilitated the transfer of the project administration from Brandeis. Suzanne Condict typed the final report.

One finding of the study was that those men who were active in supporting services to pregnant and parenting teenagers frequently became involved in this "female" issue through the intervention of women. The two male investigators, Richard Weatherley and Michael Levine, are no exception; they are grateful to their colleagues, Lorraine Klerman and Sylvia Perlman, for having drawn their attention to the issue and for educating them about it.

Finally, we wish to thank our project officers at the Office of Adolescent Family Life, Gerry Hendershot and Julia Maestas y Moores, and Donald Underwood, Grants Management Officer for their accommodating and supportive assistance.

THE AUTHORS

Richard Weatherley, Principal Investigator, is an associate professor at the University of Washington School of Social Work. He is a political scientist who has studied a variety of social welfare policy issues.

Lorraine Klerman is currently on the faculty of the Department of Epidemiology and Public Health, Yale School of Medicine. She has studied programs for pregnant and parenting adolescents since 1965 and has published her findings in numerous articles and book chapters.

Sylvia Perlman and Michael Levine recently completed their doctoral studies at Brandeis University. Michael Levine is currently Associate for Youth Policies in New York City Mayor Koch's office, and Sylvia Perlman is a consultant in the Boston area.

At the time the research was initiated, the authors were at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Professors Weatherley and Klerman as faculty, and Drs. Perlman and Levine as research associates.

Part I
Introduction and Study Design

Chapter 1. Overview and Purpose of the Study

The study addresses two central questions: how and why have local programs for pregnant and parenting adolescents been developed and maintained, and what accounts for the development and maintenance of comprehensive programs in some communities and not in others that appear equally or more needy? To find answers to these questions, we studied ten local programs in four states. The ten were comprised of five pairs matched according to basic socioeconomic and demographic characteristics. Each pair included one locality with a program that fit our definition of "comprehensive," and a second that lacked such a program. Our approach reflected what we and others thought might be significant in program development: leadership, knowledge of alternative program models, state funds, policies and technical assistance, advocacy group and interest group activities, and state and local political culture. While most of these factors were important determinants of program success, we learned that local programs development was much more difficult and complex than we had anticipated.

Adolescent pregnancy first emerged on the national political agenda as a major social problem in the late 1960's and early 70's. Among the responses was the promotion at the national, state, and local levels of an intervention model linking education, social, and health services for pregnant and parenting teenagers. This activity peaked, however, as the concept of combating social ills through large-scale federal programs was falling from favor. As a result, while state and local interest and national policy favored the development of local comprehensive programs, little money was available to fund such efforts. Nonetheless, local services, some of exemplary quality, have grown during the past 15 years. A crucial public policy question emerging from these developments is this: What can be done in an era of resource scarcity to foster the development and maintenance of programs to assist teenage parents?

In this introductory chapter, we offer a brief overview of the emergence of adolescent pregnancy as a social problem and the origins of official policies to address it. We also describe the study and the organization of this monograph.

The Making of a Social Problem

The policy interest in adolescent pregnancy peaked even as birth rates declined. Until the end of World War II, the birth rate for women 15 to 19 fluctuated between 50-60 births per 1,000 women, but then rose to a high of 96.3 in 1957 at the height of the baby boom.[1] It has since declined sharply to pre-World War II levels.[2] In 1978, for example, it was about 55 per 1,000.[2] This apparent discrepancy between falling birth rates and rising concern can be explained by several concurrent developments. But one must also look at the process whereby certain social concerns attain national prominence.

Political scientist John Kingdon suggests that the emergence of issues on the national political agenda is determined by the somewhat chance confluence of several independent occurrences: a favorable political climate; the perception of a problem requiring intervention; and the availability of politically acceptable policies to address the problem.[3] Adolescent pregnancy fits this model well. The public perception that the problem was growing, despite the falling adolescent birth rates, was fostered by a number of developments.

There were more teenage parents in the 1960's and early 70's. This was a result of the "baby boomers" reaching childbearing age, thus increasing by 25 percent the total pool of young women available to bear children. Teenage sexual activity increased and with a decline in early marriage, teen illegitimacy rates rose. These developments occurred at a time when there was general concern about the population problem.[4] Public attitudes and governmental policies began favoring family planning. The legalization of abortion made available to adolescents as well as adults what was to become a highly controversial and politicized option. Most significant from the standpoint of public concern was the fact that, in the wake of the women's and children's rights movements, white teenagers began to keep their babies as black adolescents always had. This reduced the white adoption market, and sparked concerns about the adequacy of adolescent parenting and the impact of early childbearing on both mother and child.[5]

Concerns about early childbearing seemed confirmed by initial studies, many of them sponsored by the Children's Bureau. These studies showed an association between adolescent parenthood and a number of health problems and social ills. These included toxemia, low birth weight, infant

mortality, school dropout, and welfare dependency. Such studies conducted in the late 1960's and early 70's, drew upon populations of inner-city black teenagers; but as subsequent research has shown, the findings did not equally apply to middle-class whites. In fact, more recent studies suggest that many of the problems associated with adolescent parenthood are due to the underlying conditions of poverty that afflict teenage parents, their children, and their families.[6]

Programmatic Responses

The "discovery" of adolescent pregnancy came toward the end of a period of intense social activism. Addressing the problem with services fit the tenor of the times. A number of local programs evolved which used government family planning, maternal and child health, educational, and vocational education funds, as well as private support. More than 1,000 community programs were established by the mid-1970's, and their sponsors contributed to the call for an increased federal role. There was no lack of proposals for federal intervention. The one that united a broad coalition of advocates, providers, bureaucrats, and politicians was the funding of locally administered demonstration projects emphasizing health, education, and social services in comprehensive programs. Thus two of Kingdon's prerequisites for being placed on the national agenda were met in the early 1970's with the identification of a problem, backed by both statistical and anecdotal evidence of its significance, and the promotion of policies and service programs to combat it. Only the appropriate political climate and support were missing. This proved difficult to achieve.

The politicization of adolescent pregnancy heightened incipient conflicts between those seeking to preserve the traditional family and others advocating policies to facilitate and support new, emerging family patterns. Other concerns such as child abuse or teenage drinking have been described as "valence issues."[7] Most people agree that something should be done about these problems, and would support some governmental role, though perhaps not extensive spending. On the other hand, adolescent pregnancy strikes at the heart of some very divisive issues that seriously impede policy consensus--teenage sexuality, parental control, contraception, and abortion. These issues elicit sharp differences: between those favoring prevention and those advocating services to the already pregnant and parenting; among advocates of health, education or social service approaches; between those

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stressing chastity and a stronger parental role and others favoring a children's rights perspective; and between those supporting local, voluntary program development and those favoring a strong governmental role. Early federal policy, as represented by the 1978 Adolescent Health Services and Pregnancy Prevention Act was a compromise between these conflicting factions.[8] It stressed services rather than prevention, and the preferred model was one of direct federal support of local, comprehensive programs which linked together a variety of health, education, and social services. A further compromise was to limit funding so that only a few programs could be supported each year. It was replaced in 1981 by Title XX of the Public Health Service Act under the Omnibus Budget Reconciliation Act (OBRA), and funds continued to be limited. Federal funding levels under these Acts for adolescent pregnancy programs and the number of new programs supported annually are shown in Table 1-1.

At the time this study was initiated (1981) there was widespread public and governmental concern about the consequences of adolescent pregnancy and childbearing, but sharp disagreement about what should be done. Federal policy fostered the development of local comprehensive service programs, but provided minimal direct support. Nonetheless, many programs had been developed; while few could be termed comprehensive, there were some that observers had deemed exemplary.

Table 1-1

Funding (in $ millions) for Title VI and Title XX Adolescent Pregnancy Initiatives, FY 1979-1984

Fiscal Year	Program	Authorization	Appropriation	New Programs*
1979	Title VI	50	.74	4
1980		50	6.4	23
1981		50	8.0	12
1982	Title XX	30	10.0	50**
1983		30	11.7	10
1984		30	13.4	14

Source: Office of Adolescent Family Life Programs, U.S. Public Health Services

*This reflects only newly funded programs since most programs received multi-year contracts. Research awards not included.

**Includes former Title VI grantees who applied for Title XX funding.

Organization of the Monograph

Part I, Chapter 2 sets forth the study design and methodology. It examines several alternative definitions of comprehensive services and presents the one used in the study. Site selection, sample characteristics, and data collection and analysis are also described.

Part II, Chapters 3-6, presents case studies of program development in each of the ten localities studied.

Part III, Chapters 7-9 presents the findings and conclusions of the study. Chapter 7 describes the local environment and constraints to program development. The local conditions associated with successful program development and the strategies used to overcome the constraints are discussed in Chapter 8. In Chapter 9, we summarize the findings and discuss their implications for public policy. Part III, Findings and Conclusions, may be read independently of the case descriptions in Part II. However, familiarity with the case studies will make the findings more meaningful.

NOTES

1. Frank F. Furstenberg, Jr. Unplanned parenthood: The social consequences of teenage childbearing. New York: The Free Press, 1976, pp. 7-8; and Maris A. Vinovskis. An "epidemic" of adolescent pregnancy? Some historical considerations. Journal of Family History, Summer 1981, 205-230.

2. Alan Guttmacher Institute. Teenage pregnancy: The problem that hasn't gone away. Washington, D.C.: 1981, p. 24.

3. John W. Kingdon. Agendas, alternatives, and public policies. Boston: Little, Brown, & Company, 1984.

4. Furstenberg. Unplanned parenthood.

5. Furstenberg. Unplanned parenthood; Melvin Zelnick and John F. Kanter, Contraceptive patterns in premarital pregnancy among women aged 15-19 in 1976. Family Planning Perspectives, 10(3), May/June 1978, 135-142; Theorodora Ooms (Ed). Teenage pregnancy in a family context: Implications for policy. Philadelphia, PA: Temple University Press, 1981, esp. Chapter 1 by Ooms.

6. Elizabeth R. McAnarney, M.D. (Ed.). Premature adolescent pregnancy and parenthood. New York: Grune and Stratton, 1983, esp. Dorothy R. Hollingsworth et al., Impact of gynecological age on outcome of adolescent pregnancy, Chapter 9, pp. 169-190; Ruth A. Lawrence and T. Allen Merritt, Infants of adolescent mothers: Perinatal, neonatal and infant outcome, Chapter 8, pp. 149-168; E. Milling Kinard and Lorraine V. Klerman, Effects of early parenthood on the cognitive development of children, Chapter 14, pp. 253-265; and James F. Jekel and Lorraine V. Klerman, Comprehensive service programs for pregnant and parenting adolescents, Chapter 17, pp. 295-310.

7. Barbara J. Nelson. Making an issue of child abuse: Political agenda setting for social problems. Chicago, IL: University of Chicago Press, 1984.

8. Gilbert Y. Steiner. The futility of family policy. Washington, D.C.: The Brookings Institution, 1981.

Chapter 2. Defining Comprehensive Programs: Study Design

Introduction

The process of designing the study, selecting states and localities, and collecting and analyzing the data was complex. Decisions had to be made about defining "comprehensive," choosing states and localities for inclusion in the study, and identifying relevant actors to interview. The lack of current data on programs and their characteristics and the considerable variation from program to program in emphasis, services and clientele complicated this process. For example, the descriptive labels for services ("referral," "follow-up," "education," "outreach," "counseling," etc.) have different meanings in different places. While we were able to draw upon a number of prior studies, considerable effort was expended identifying the current status of state and local programs before a suitable sample could be drawn.[1]

Comparative Case Study Design

States offering different approaches to local service provision were selected and the experiences of localities within these states compared. (The term "locality" is used here to denote the geographical/governmental unit served by local programs. It is used in preference to "community" which suggests a dimension of social cohesion and a coherence of jurisdictional boundaries that the more neutral "locality" does not.)

Four states were selected for study: Massachusetts, Michigan, California, and Tennessee. Within each state, we then selected a matched pair of localities. However, in California two matched pairs (four sites) were selected in consideration of the size, population, and extensive service development in that state. Our final sample was comprised of four states and ten localities within these states. We sought to select sites that had successfully developed comprehensive services for pregnant and parenting adolescents and compare them, insofar as possible, with demographically similar sites that lacked comprehensive services.

Political scientists have long recognized the importance of studying non-decisions as a means of understanding how and why particular issues come to be placed upon or excluded from public policy agendas.[2] Similarly, we believed it was as

important to learn why services do not get developed in some localities as it was to learn why they do in others. This comparative case study design enabled us to analyze the development and maintenance of services in several complementary ways. We examined and compared the unique features in each matched pair to determine why services were developed in one place but not another. We looked for common characteristics shared by the five comprehensive and five non-comprehensive sites. We also assessed common features shared by all ten sites. Finally, we examined the effects of state policies on local programs within each of the four states, and compared the policies of the four states with one another.

Defining Comprehensive Services

The first step in identifying potential sites was to operationalize the term, "comprehensive services." We had to reconcile a conceptual definition of comprehensiveness with the limited number of programmatic examples to be found across the country. Too restrictive a definition (requiring many core services) would eliminate all but a few exemplary programs from possible inclusion in our sample; too broad a definition (requiring only a few services) would render meaningless a comparison between sites with comprehensive programs and those without.

Table 2-1 shows the required and optional components of comprehensive service programs under various definitions. Forbush and Jekel found that only 4.8 percent (54 out of 1,132) of the programs listed in the 1976 NACSAP Directory provided all three of the "classical triad" of services: education, social services, and health services, including pre and postnatal care. Even within these presumably comprehensive programs, 37 percent did not provide contraceptive information to the mothers; 75 percent offered no family planning information for fathers; 63 percent offered no infant care; 63 percent provided no job placement assistance; 50 percent did not offer adoption services; and 20 percent lacked parenting education.[3]

The Adolescent Health Services and Pregnancy Prevention Act (PL 95-626, Health Services and Centers Amendments of 1978) offered the first authoritative national definition of "core" services. Grantees were required to offer, either in a single setting or by means of a linked referral network, the following:

1. Pregnancy testing, maternity counseling and referral services.

2. Family planning services.

3. Primary and preventive health services including pre and postnatal care.

4. Nutrition information and counseling.

5. Adoption counseling and referral services.

6. Educational services in sexuality and family life.

Referral for:

7. Screening and treatment of V.D.

8. Pediatric care.

9. Educational and vocational services.

10. Other health services.

"Supplemental services," which might be provided, included:

1. Child care.

2. Consumer education and homemaking.

3. Counseling for extended family members.

4. Transportation.

The Adolescent Pregnancy Act, as PL 95-626 came to be known, was repealed under the 1981 Omnibus Reconciliation Act (OBRA) and replaced by Title XX of the Public Health Service Act which provided for "Adolescent Family Life Demonstration Projects." While the new legislation allowed the Secretary of the Department of Health and Human Services to determine what should be considered "core" and "supplemental" (i.e., required and optional), it did identify a number of necessary services as follows:

Table 2-1. Comprehensive Service Components

Service	Forbush and Jekel	PL95-626 1978	Title XX PHS Act 1981	JRB Report 1981	Our Definition Used in Site Selection
Pregnancy Testing	0	+	+	+	+
Family Planning Services	+	+	+	+	+
Pre and Postnatal Care	+	+	+	+	+
Nutrition Information	+	+	+	+	+
Adoption Counseling, Referral	0	+	+	+	+
Education in Sexuality, Family Life	?	+	+	+	+
Referral to Other Health Services	?	+	?	+	
VD Screening	?	+	+	+	
Pediatric Care	+	+	+	+	
Educational, Vocational Services	+	+	+	+	+
Child Care	+	*	+	*	
Consumer Education	?	*	+	*	
Counseling for Extended Family	?	*	+	*	
Transportation	?	*	+	*	
Mental Health Services	?	?	+	?	
Outreach to Families of Adolescents	?	?	+	?	
Services to Fathers	+	?	?	+	
Follow-up after Delivery	+	?	?	+	
Abortion	+	Forbidden	Forbidden	?	
Parenting Education	+	?	?	?	
Housing	0	?	+	?	
Legal Assistance	0	?	?	?	

Key: + = considered necessary to a "comprehensive program," either on site or by referral
? = not mentioned
0 = mentioned but not required
* = "Supplemental"

1. Pregnancy testing and maternity counseling.

2. Family planning services.

3. Primary and preventive health services including prenatal and postnatal care.

4. Nutrition information and counseling.

5. Adoption counseling and referral services.

6. Educational services relating to family life and problems associated with adolescent premarital sexual relations.

7. Educational and vocational services and referral to such services.

8. Mental health services and referral to mental health and to other appropriate physical health services.

9. Child care.

10. Consumer education and homemaking.

11. Counseling for extended family members.

12. Transportation.

13. Outreach services to families of adolescents to discourage sexual relations among unemancipated minors.

Referral for:

14. Screening and treatment of V.D.

15. Licensed residential care or maternity home services.

16. Pediatric care.

The most current and complete national data on comprehensive services available at the time of the study were those found in the 1981 directory prepared by JRB Associates, Inc.[4] This study, based on a survey of 1,117 programs, was conducted under contract from the DHHS Office of Adolescent Pregnancy Programs. It essentially used the ten "core" services of the 1978 Adolescent Pregnancy Act as its

definition of comprehensive programs. A total of 274 programs (25 percent) qualified for inclusion as comprehensive. While this suggests a substantial increase in the number of comprehensive programs during the five-year period between the NACSAP and JRB surveys, firm conclusions cannot be drawn[5] because of differences in the criteria and methods employed.

Another complicating factor is the extent to which service networks, comprised of discrete and dispersed organizations, are coordinated and linked administratively. The 1978 Adolescent Pregnancy Act called for improved coordination and linkages, but left unspecified whether programs supported under the legislation had to have written referral agreements with other agencies offering core or supplementary services. This is a particularly important issue for a service model that contemplates "linkages" among several providers, as was pointed out in testimony on the proposed regulations for the Act. The final regulations did not require written referral agreements, but they did give priority to projects offering evidence of such agreements.

Our definition. A review of the pertinent legislation, program surveys, and provider and academic commentary suggests some consensus on the essential ingredients of a comprehensive program, whether provided totally on-site or through a linked referral network. These are:

health services, including contraceptive services, prenatal and postnatal care;

academic and/or vocational education;

nutrition information; and

social services and counseling for adoption, adolescent sexuality, and family life.

This rather minimal definition is the one we adopted for purposes of site selection. It is worth noting that we did not include as selection criteria a number of services some observers consider essential: follow-up after delivery; child care; counseling for the adolescents' extended families; transportation; services for fathers; parenting education; abortion counseling and services; and financial and housing assistance.

Site Selection: States and Localities

Our goal in selecting the study states was to derive a sample that included: a) states with and without policies to encourage the development of comprehensive programs; and b) only states offering potential local program matches. We also sought, insofar as possible, some geographic as well as programmatic diversity. We made an initial decision to exclude very large cities (over 500,000 in population) as well as programs that were well known or previously studied as exemplary. The exclusion of large cities was decided primarily on pragmatic grounds. With limited time and staff resources, we elected to cover more, but smaller, localities in order to expand our sample size. Many of the programs generally acknowledged as exemplary had been initiated and sustained because of unusual circumstances that could not be easily replicated in other sites: for example, the sponsorship of a major research or teaching hospital, the provision of special resources, or the cooperation of an unusually progressive school system. These were eliminated from the selection process.

We began by examining the distribution, by state and region, of comprehensive programs. For identification of specific programs, we used the JRB Directory and listings of Family Focus, Project Redirection, Mott Foundation, and DHHS Office of Adolescent Pregnancy Programs projects. For information on state policies, we initially consulted a 1980 survey conducted by the National Association of State Boards of Education (NASBE).[6] However, for both individual programs and states, we found it necessary to supplement the published data through telephone interviews with national and state officials, advocates, and services providers. What we found in attempting to derive a sampling frame was confirmed in the study: programs come and go rapidly and services are in constant flux.

The site selection process was carried out inductively. Starting with the universe of states and localities, we made several cuts, each time narrowing the selection to fewer and fewer sites. After considering many potential candidates, we selected three policy states (Massachusetts, Michigan, and California), each exemplifying a somewhat different approach; and one non-policy state (Tennessee). (A policy state is one having both policies and resources to facilitate and support the development and maintanence of local service programs for pregnant and parenting adolescents.)

We selected states that offered the possibility of finding non-comprehensive localities to compare with comprehensive sites. We sought non-comprehensive sites of similar size with comparable socioeconomic characteristics to the extent possible.

At the time we constituted the sample, about half the states had three or less comprehensive programs. One of our sample states, Tennessee, is in this category, with only three identified comprehensive programs. Tennessee, like many of the southern states, ranks low in terms of spending for education and social welfare, but is also among those states having the highest adolescent fertility rates. Like most of the states, it has no specific policies or resources to facilitate the development and maintenance of adolescent pregnancy programs.

The other three states in the sample, Michigan, Massachusetts, and California, have traditionally been innovators of social welfare programs and policies. This tradition has extended to the development of comprehensive adolescent pregnancy services. The three are among a group of approximately eight states that have policies and resources fostering local service development. They are also among those states with the largest number of identified comprehensive programs: 31 in California; 21 in Massachusetts; and 14 in Michigan. At the same time, all three have recently suffered severe revenue shortfalls, and in the cases of California and Massachusetts, budget limitation measures. The three, while pursuing different policies, represent states responsible for much of the program development in services for pregnant and parenting adolescents.

Tables 2-2 and 2-3 show how the four study states compare with respect to several socioeconomic indices and health, education, and welfare policies. Despite their differences in population and their location in different parts of the country, California, Massachusetts, and Michigan are similar in income, percent below the poverty line and AFDC grant levels. Michigan shows much higher unemployment and somewhat lower average educational attainment. Massachusetts has a lower rate of births to teenagers than the other states. Tennessee stands out from the other three states with much higher levels of poverty, lower educational attainment, and much lower AFDC grants and per pupil educational expenditures. It also has a significantly higher percentage of births to teenagers.

The population characteristics of the local study sites are shown on Tables 2-4 and 2-5. The ten sampled localities range in population from 11,000 to 340,000. Missing are both large cities and rural areas, both of which may have unique features that warrant further study. One further characteristic of the sample deserves mention: it includes no hospital-based models, possibly a function of our decision to exclude well-known, exemplary programs and programs in large cities.[7]

Data Collection and Analysis

The field research was conducted throughout 1983. A total of 229 persons were interviewed, some several times in the course of the study. Respondents were selected because of their official positions and responsibilities, by reputational means, or both. (None of the program clients were interviewed. A breakdown of state and local respondents is shown in Table 2-6). We first identified those individuals who had official roles with respect to the development and maintenance of comprehensive services. We then supplemented this list by asking each informant to identify others knowledgeable about the origin, development, and maintenance of the programs. We endeavored to include a broad spectrum of perspectives, including, whenever possible, critics as well as supporters of services. With only two exceptions, all of the prospective respondents agreed to participate. The interviews were conducted using separate protocols for the state and local respondents. Most interviews were carried out jointly by two investigators who recorded and coded the responses independently. The Principal Investigator also coded the interviews, and in the few instances where there were discrepancies, they were resolved through joint deliberations or by telephone follow up with the respondent.

In addition to the interview data, we also collected program and demographic statistics at the state and local levels, and policy statements, regulations, program descriptions, and news clippings pertaining to our sites. Our goal was to determine how and why programs were developed and maintained, and to learn what constraints impeded program development. At the state level we wanted to ascertain what programs existed throughout the state and how they were viewed; we also sought to learn about the origin and implementation of pertinent state policies and the role of the legislature, executive agencies, and coalitions and advocacy groups with respect to services for pregnant and parenting adolescents. At the local level, we wished to know how,

when, and why adolescent pregnancy gained (or failed to gain) salience as an issue requiring programmatic response; and what factors shaped the nature of the response.[8] These questions provided the basis for the major coding categories, and additional categories emerged from the analysis of the data.

Table 2-2

Socioeconomic Characteristics of Four Study States

STATE	CALIFORNIA	MASSACHUSETTS	MICHIGAN	TENNESSEE
POPULATION	23,667,902	5,737,037	9,262,078	4,591,120
% Black	7.2	3.9	12.9	15.8
% Spanish Origin	19.2	2.5	1.7	.7
INCOME				
Median Family	$21,537	$21,166	$22,107	$16,564
% Fams./Poverty	8.7	7.6	10.4	13.1
LABOR FORCE				
% Unemped. '83*	9.7	6.9	14.2	11.5
Employed persons: % in mfs. & indust.	20.3	26.0	30.3	26.7
Managerial/Prof'al Specialty occups.	25.1	26.2	21.4	19.7
EDUCATION				
Persons 25 & over:				
% H.S. grads.	73.5	72.2	68.0	56.2
% 4/more yrs. college	19.6	20.0	14.3	12.6
FERTILITY - 1978**				
Total Births	356,310	68,657	136,149	66,607
Births: under 20	53,896	7,823	21,899	14,220
% births to teens	15.1	11.4	15.7	21.3

Data Sources: Except as noted, source for all data is 1980 Census of Population, Vol. 1, Chapter B or C. PCIO-1. Washington, D.C.: U.S. Bureau of the Census,
Issued Sept. 1981.
*Employment Data from: CA Employment Devt. Dept. MA Division of Employment
Security, MI Employment Security Commission, TN Dept. of Employment Security.
**Fertility statistics from Vital Statistics 1978, U.S. Dept. of Health and Human Services.

Table 2-3

Selected Policy Characteristics of Four Study States

STATE	CALIFORNIA	MASSACHUSETTS	MICHIGAN	TENNESSEE
VARIABLE				
WELFARE (1980)				
AFDC: Max. Monthly grant (family of 3)	$463	$379	$462	$122
Combined max. AFDC/ Food Stamps:				
As % of 1980 Povty. Threshold	104%	93%	104%	56%
As % of State per Capita Income	62%	60%	69%	47%
EDUCATION				
Spending per pupil: Amount, 1982	$2427	$2964	$2652	$1831
Rankings, 1982	22	10	19	45
HEALTH				
Medicaid outlays per Recipient, '80	$798	$1288	$1101	$1071

Sources: Welfare and Medicaid outlays data from ACIR Intergovernmental Perspectives, 8 (Sp. 1982), p. 14.
Education data from The New York Times, January 6, 1984, "Dropout Rate is Up Sharply in U.S. Schools, Survey Says," Medicaid availability data from Children's Defense Fund, 1984.

Table 2-4

Sociodemographic Characteristics of California and Massachusetts Study Sites

	CALIFORNIA				MASSACHUSETTS	
	Fresno*	Oakland	Elk Grove*	Santa Maria	Worcester*	Lowell
POPULATION	218,202	339,337	10,959	39,685	161,799	92,418
Race - White	137,351	119,347	9,713	23,258		89,089
- Black	20,943 (9.6%)	157,484 (46.4%)	56 (.5%)	849 (4.3%)	6,877 (4.3%)	1,172 (1.3%)
- Spanish Origin	51,271 (23.5%)	32,133 (9.5%)	876 (8.0%)	13,206 (33.5%)	4,625 (2.9%)	4,536 (4.9%)
INCOME						
Median Family Income	17,720	17,651	24,935	18,526	18,120	17,942
% Families Poverty	12.6	16.0	6.7	9.5	11.2	11.3
LABOR FORCE						
% Unemployed, 1983	12.2	11.7	N/A	12.2	7.6	5.5
Employed persons 16 & over- % in mfg. and industries	11.2	14.3	9.2	N/A	27.2	41.6
% Mngrl. & Prof'l speciality	23.5	26.0	29.6	N/A	22.8	16.6
EDUCATIONAL CHARACTERISTICS						
Persons 25 & over - % High School Graduates	67.9	71.5	81.0	65.1	62.6	57.7
% 4 or more yrs. college	16.5	21.8	18.2	10.5	14.8	10.4

*Comprehensive sites.

Sources: All data except for unemployment rates from the 1980 U.S. Census; California unemployment rates are from the CA Employment Devt. Dept., and Massachusetts unemployment figures are from the MA Div. of Employment Security.

Table 2-5

Sociodemographic Characteristics of Michigan and Tennessee Study Sites

Source for all data, except as noted, is: 1980 Census of Population, Vol. 1, Chapter B (General Population Characteristics) or chapter C (General Social and Economic Characteristics), PC 80-1-. Washington, D.C.: Bureau of the Census, Issued Sept. 1981.

	MICHIGAN		TENNESSEE	
	Kalamazoo*	Saginaw	Chattanooga*	Knoxville
POPULATION	79,722	77,508	169,550	175,030
Race - White	65,463	44,786	114,523	147,892
- Black	12,432 (15.6%)	27,598 (35.6%)	53,792 (31.7%)	25,438 (14.5%)
- Spanish Origin	1,375 (1.7%)	7,000 (9.0%)	1,274 (.07%)	1,317 (.07%)
INCOME				
Median Family Income	$18,617	$17,672	$16,706	$15,676
% Families Povety Level	13.7	18.4	13.4	13.9
LABOR FORCE				
% Unemployed, 1983	11.7	19.6	10.1	10.0
Employed persons 16 & over - % in mfg. and industries	21.1	31.4	23.7	15.4
% Managerial & Professional speciality occupations	26.1	15.4	21.8	23.6
EDUCATIONAL CHARACTERISTICS				
Persons 25 & over -				
% High School Graduates	73.4	57.6	60.5	61.4
% 4 or more yrs. college	26.8	8.4	14.1	17.4

*Comprehensive sites
Sources: All data except unemployment rates from 1980 U.S. Census. Unemployment data from the MI Employment Security Commission and the TN Dept. of Employment Security.

Table 2-6

State and Local Respondents by Position

	State Respondents	Local Respondents	Total
Bureaucrat/Analyst	45		45
Elected Officials	11	9	20
Service Providers		49	49
Administrators		83	83
Academics, Advocates, & Volunteers	14	18	32
Total	70	159	229

NOTES

1. Gail Zellman. Response of schools to teenage pregnancy and parenthood. Rand Corporation, submitted to the National Institute of Education, April 1981; JRB Associates, Inc. Final report on national study of teenage pregnancy. Submitted to the Office of Adolescent Pregnancy Programs, DHHS, August 15, 1981; H. Goldstein and H. Wallace. Services for and needs of pregnant teenagers in large cities of the United States. Public Health Reports 93, January-February 1978, 46-54; James Jekel and Janet Forbush. Characteristics of programs serving pregnant adolescents in the United States. Paper presented at the annual meeting of the American Public Health Association, 1977; H. Wallace, J. Weeks, and A. Medine. Services for and needs of pregnant teenagers and their infants in the large cities of the United States, 1979-1980. Unpublished paper, Graduate School of Public Health, San Diego State University, October 1981; S. Alexander, C. Williams, and Janet Forbush. Overview of state policies related to adolescent parenthood. Washington, D.C.: National Association of State Boards of Education, 1980; Lucy Eddinger and Janet Forbush. School-age pregnancy and parenthood in the United States. Washington, D.C.: National Alliance Concerned with School-Age Parents, 1977.

2. Peter Bachrach and Morton Baratz. Power as non-decision making. In Edward Banfield (Ed.), Urban government. Glencoe, IL: Free Press, 1961, pp. 454-464.

3. Jekel and Forbush. Characteristics of programs.

4. JRB Associates, Inc. Final report.

5. James F. Jekel and Lorraine V. Klerman. Comprehensive service programs for pregnant and parenting adolescents. In Elizabeth R. McAnarney, M.D. (Ed.), Premature adolescent pregnancy and parenthood. Grune and Stratton, 1982, pp 295-310.

6. S. Alexander et al. Overview of state policies.

7. The JRB Associates survey found that 13 percent of the programs were based in hospitals, 17 percent in schools, 31 percent in social agencies, 10 percent in health

departments, and 29 percent in other kinds of settings. Our sample appears fairly representative in terms of agency setting.

8. Two doctoral dissertations based on the study considered respectively the politics of adolescent pregnancy and the implications of the current funding mechanisms. See Sylvia B. Perlman, Nobody's baby: The politics of adolescent pregnancy; and Michael Levine, On the brink: Programs for pregnant and parenting teenagers in ten American communities, dissertations presented to the faculty of the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, November 1984.

Part II

State and Local Case Studies

Chapter 3. California

I. STATE POLICIES AND PROGRAMS

California's 25 million residents comprise more than 10 percent of the nation's population; by the year 2000, it will probably be about 20 percent. It has the largest Hispanic (5 million) and Asian (1.5 million) populations and one of the largest black populations (2 million) in the United States. Although its per capita income ranks fifth in the country, there are more than 3 million Californians who are below the poverty line.[1] In 1980, more than 1.5 million Californians received AFDC, and many more received Food Stamps and MediCal benefits. California has the most births, abortions, deaths, divorces, and marriages in the United States.

California has traditionally approached its public problems with vigor. Many California programs have served as models for legislation nationally and in other states. As the discussion below indicates, this leadership has extended to programs affecting pregnant and parenting teenagers.

State Programs for Pregnant and Parenting Teenagers

Perhaps the most important factor affecting state programs is the realignment of revenue contributions that took place as a result of Proposition 13. Passed by a two-thirds plurality of Californians voting in June 1978, Proposition 13 dramatically reduced property tax levies that had been the major revenue source for the state's 5,000-plus local governments. Directly following passage, the state legislature put together a bail-out package to smooth the transition by supplementing local service dollars over a three-year period. This was made possible by a large budget surplus. The recession of 1981-82 and the bail-out's exhaustion of the revenue surplus have contributed to a budget crisis at the state level. Governor George Deukmejian took office in January 1983 and immediately cut spending for the remainder of that fiscal year and used his line-item veto to reduce the 1984 budget significantly. (The state's economy is now recovering; the governor forecasts a budget surplus for the 1985 fiscal year.)

Local service providers are just now feeling the impact of Proposition 13. Because of the cushion provided by the bail-out, many programs for pregnant and parenting teens were maintained between 1979 and 1981 (usually at level funding). Now, the impact is hitting local health, social service, and especially education agencies.

Before Proposition 13, school districts were far more dependent on local property taxes. With Proposition 13, most of the burden was placed on the state, resulting in what one observer[2] termed "de facto state assumption of school finance."[2] The state share of local education costs rose from 30 to 70 percent in the year after Proposition 13 was enacted.[3] It is difficult to separate the impact of Proposition 13 from the concurrent state emphasis on school finance reform (pursuant to the Serrano decision mandating inter-district equalization). The trend towards state assumption is clear as is the resultant pressure to reduce per-pupil expenditures.

In sum, in California, state education programs are under pressure from three sides: the scarcity of state funds, the removal of a local revenue generator, and school finance equalization. As in the other study states, budget shortfalls shape a significant part of the policy context for the development of services for pregnant and parenting adolescents. In California, revenue limitations have hurt local service provision disproportionately because of the emphasis this state has placed on developing school-based models of intervention.

Department of Education

More than 53,000 California teenagers give birth each year. This includes 800 under the age of 15.[4] Recognizing that many of these teens are of school age and that their pregnancy is commonly associated with school drop-out, the California state Department of Education (DOE) has taken the lead in developing special services. These programs vary in their emphasis, comprehensiveness, funding source and level, and in local community participation rates. The major programs are described below.

The Pregnant Minor Program (PMP)

The PMP has existed as a state-funded program since 1968; it was originally placed under the administration of the

Office of Special Education (OSE). The intent of the program is to "provide a continuous educational program of secondary curriculum, prenatal and postnatal instruction, nursing services, nutritional information, parenting education, and a social environment conducive to a positive self image for the pregnant student."[5] Decisions about whether to develop a program are left to local school districts and county Offices of Education. Local discretion determines whether pregnant minors would be offered a special class, home instruction, a program within a hospital setting, or a program integrated into a continuation high school. Eligibility for the PMP is limited to students who have verified pregnancies, and it continues until the end of the semester during which the delivery occurs. After delivery there are few special services for teen parents, usually leaving the student to drop out or re-enroll in her regular high school. Under the Office of Special Education, state administration was minimal. Funding was available through state "Special Education Allowances" that supplemented reimbursements to local districts based on Average Daily Attendance (ADA). The reimbursement arrangements allowed substantial flexibility for local program development; however, this flexibility together with the lack of administrative oversight permitted local districts to avoid meeting the ambitious goals of the program. Furthermore, the lack of start-up funds constrained program development. Few, if any, localities developed comprehensive PMPs.

In July 1980, the legislature removed the Pregnant Minor Program from Special Education, established a new funding mechanism, and directed the Superintendent of Public Instruction to adopt regulations for administering the programs. The Department of Education then transferred administrative responsibility from Special Education to the Office of Child Development (OCD).

During fiscal years 1980 and 1981, the OCD worked to establish standards for these programs, but it was not until the beginning of fiscal year 1983 that regulations were adopted. Implementation of OCD oversight authority was delayed because the legislature had inadvertently failed to attach additional funding for state administration of the programs. The OCD claimed that it was already overburdened with responsibility for monitoring SAPID programs, as well as every other public day care program in the state. The PMPs were effectively in limbo, without oversight, for three years (1980-1983); only recently have OCD officials even compiled a list of programs that they are required to oversee.

Advocates claim that local districts closed programs or diminished services while state officials "weren't looking." According to the 1980 statute shifting administrative responsibility, localities with PMPs were required to continue them and would receive new "categorically formula-funded" state dollars, about 9 percent above ADA for each pregnant minor. Local agencies wishing to establish new programs were told they would have to apply to the Superintendent of Public Instruction for authority. To our knowledge, procedures for doing so were never developed, and there has been no local expansion of the program. About 3,500 students were enrolled in 1979-1980. Since monitoring and oversight is limited, current enrollment data or assessments of scope and quality of local services are not available. A statewide advocacy group, the California Alliance Concerned with School Age Parents (CACSAP), estimated in 1980 that only 15 percent of all eligible students were enrolled in PMPs. It is likely that this percentage has declined further since that time.

School Age Parenting and Infant Development (SAPID)

The current status of SAPID is less confusing. SAPID legislation was passed in 1974 and focused on establishing mainstream pregnancy and parenting programs for teens. From its inception, the program was designed to treat the pregnant population as one that must stay in school through pregnancy and after delivery, preferrably in a location where their peers were also receiving their education. In contrast, the PMPs had generally been placed by local school districts in churches, alternative schools, recreation centers, and other settings removed from the comprehensive high school.

The SAPID legislation stressed two primary goals: first, "the education of the school-age parent, including classes in the role of parenting education, opportunities for career development, and the completion of the high school curriculum resulting in a diploma,"; second, "the care and (provision of) developmental services for the infants of these school-aged parents."[6] In 1975, 13 sites received funding from the OCD under a $600,000 appropriation. The programs were selected through a competitive RFP (Request for Proposal) process; there were 85 applicants the first year. The program grew rapidly before leveling off in 1980. It is currently funded at $4.3 million annually and operates in 64 sites. There are currently no funds for additional sites; districts wishing to start new programs must wait for others to terminate their programs. Districts that have programs have difficulty expanding, especially if they do not have the physical

capacity to house new students in current facilities. The RFP system no longer operates; programs now are simply renewed from year to year if they meet state program standards.

In most SAPID programs, the students participate in the regular high school program where they have access to the full curriculum. In addition, depending upon the local district, career counseling, nutrition, and parenting education specially designed for pregnant and parenting students are available. In other cases, local programs can operate out of "continuation schools" that emphasize vocational education. In addition to the earmarked funds, SAPID schools also receive regular "Average Daily Attendance" (ADA) reimbursements. The Local Education Agency (LEA) may also draw upon its general school revenues to supplement these funds. At the end of the 1982-83 school year, a total of 2,222 parents and children were enrolled in SAPID programs, roughly half parents and half infants or toddlers. The average cost per enrollee above ADA is approximately $2,000 per year. This money goes towards the day care, parenting education, transportation, and nutritional components of the SAPID program. Some schools also supplement this with funds from other sources.

To be eligible for SAPID, a student must be enrolled in secondary school. The SAPID legislation also requires that at least 15 percent of program participants be non-parents; most of these are pregnant students.

According to the SAPID guidelines, the local agency administering a program (either a local school district, a county superintendent of schools, or a subcontractor) must provide all of the following services to program enrollees.

For Parenting and Non-Parent Students:

- Supervised infant care during school hours.
- Representation on the Infant Center Advisory Council.
- Instruction in parenthood education.
- Instruction and experience in child growth and development.
- Instruction in family planning and human sexuality.

- Instruction and experience in career development opportunities.

- Instruction to complete regular high school education resulting in a diploma.

For Infants and Toddlers:

- Care in licensed child care facility.

- Physical and emotional monitoring.

- Educational stimulation beginning at earliest states of development.

- Health screening, referral, and follow-through review.

- Proper nutrition planned under supervision of a nutritionist.

- Social services to children and their families (includes group discussion, individual counseling, and home visits).

- Opportunities for children to interact with their parents at the center.

Infant care centers are located in or near the school campus so that students can attend school and interact with their babies during the school day. Transportation for both students and infants is provided by the program.

In practice, many of these mandated services are not provided. An evaluation in 1978 (the only one ever conducted), while generally favorable, suggested that the program goals were too ambitious.[8] Social services and health screening were absent from many programs. In recent years, services have contracted further because of the lack of funds and significant OCD administration problems.

The Office of Child Development

The OCD was established in 1972 in accordance with the state's Child Development Act. This legislation placed administrative responsibility for all publicly subsidized child development programs within the Department of Education's Office of Child Development and defined child development to include an educational component. The OCD has administrative

responsibility for approximately $250 million for day care programs. Its monitoring capability has been severely limited by funding shortages and poor administration. Funding limitations have made evaluations of programs more difficult; field reviewers have had to contend with declining travel budgets and increasing responsibilities. (The Department has recently increased the size of its reorganized service regions.) The Department funds eight categories of day care programs (of which SAPID is one), but does not specialize in its technical assistance and evaluation activities. Field specialists are all program generalists. Monitoring is confined primarily to compliance review which consists of reporting on the number of enrollees, attendance, and cost-accounting. SAPID programs, for example, have not had formal evaluation of program effectiveness to determine numbers and rates of school retention and high school graduation, employment, and repeat pregnancies.

OCD is also plagued by controversy regarding its handling of funds. The Office came under severe attack in 1982-83 when it was cited by an internal "whistleblower" and a state audit report for inappropriately reimbursing local providers for services that were not under contract. Former administrators of OCD were frequently criticized by our study respondents; one senior legislative analyst called the administrative capacity in the office "God's worst." The Office has recently been reorganized for the third time in the last few years.

The limited state administrative capacity has inhibited the coordination of the PMP and SAPID programs. Such coordination would provide for a continuity of services for students from pregnancy into parenthood. The two programs were designed to educate two different populations. The PMP serves pregnant students outside the mainstream as "handicapped individuals"; the SAPID serves pregnant and parenting students and their children within the regular school setting. In some local school districts, the two are operated jointly to serve both pregnant and parenting students in a continual process. (See "Fresno" and "Elk Grove" below.) The PMP provides funds primarily for pregnant students, often funding an additional teacher, health educator, or both (depending on enrollments) through its special add-on to ADA. The SAPID concentrates on parenting education and infant care. Many school districts with PMPs have never received SAPID funds and cannot provide school-based day care for their parenting teens. This failure makes it more difficult for PMP "graduates" to remain in school; in California, as in other states, low cost, subsidized infant day

care is scarce. The lack of clear OCD reimbursement standards also creates confusion among local service providers. Several of our study respondents told us that combining PMPs and SAPIDs was illegal because they could not avoid "double counting." (This is untrue as long as the programs are kept administratively separate and ADA is not captured for the same student enrolled in the two programs.)

While many state advocates and local service providers see the potential benefit of merging the two programs, some are concerned about the intermingling of pregnant with parenting students. The California Alliance Concerned with School Age Parents (CACSAP), an active membership and lobbying organization, has fought to keep the two programs separate. They argue that if students in the PMP are separately housed, they will be more free to make their own, unbiased decision about the pregnancy resolution. Said one CACSAP official, "We see a key distinction between the two programs. In the SAPID, there is a lot of group pressure on any pregnant student to keep the prospective child. We are interested in counseling options, to explore all alternatives." CACSAP does support the combination of SAPID and PMP programs on those high school campuses in which each can maintain some degree of physical separateness.

Other Department of Education Programs

The Department of Education is responsible for two other programs targeted towards pregnant and parenting adolescents. The first is the Parent Involvement and Education project initiated in fiscal 1983. This project competitively awards minigrants (18 grants of $10,000 each in 1983) to school districts that develop programs to increase communications between parents and school, parents and children, and children and seniors. Several projects have focused on the implications of adolescent pregnancy for intergenerational ties and family functioning. The second area of DOE involvement is in administering Sub-part 5 of the federal Vocational Educational Amendments of 1976 (PL 94-482). This legislation encourages outreach programs for young children, school-age parents, and single parents among other groups. California has taken advantage of various provisions of this legislation by promoting seven model sites for parenthood education across the state. In 1982, the Department disseminated a Curriculum Design for Parenthood Education that included a special unit on prevention of teen pregnancy. California local districts, especially those defined as economically depressed areas

(EDAs) have also been able to use Vocational Education funds to create Regional Occupation Centers (ROCs) which have often helped pregnant and parenting teens in job readiness training.

Fresno and Bakersfield are among the most innovative local school districts. Each independently has created a model that is referred to as the Parent and Childhood Enrichment (PACE) program. The special name for these programs comes from each city's early involvement with the state Vocational Education Department's special funding for developing parenting education programs that emphasized funding sources and program elements including PMP, SAPID, Vocational Education, and Parent Involvement. These localities are thus able to provide a continuum of comprehensive services that allow for special attention to the needs of many teenagers, especially those who are pregnant or parenting.

Health and Welfare Agency

Within the Health and Welfare Agency, California's other super agency that spends about one-third of the state's annual budget, there are few specific initiatives that focus direct attention on this population. However, several policies are of relevance to the pregnant or parenting adolescent.

Welfare Policies

California income assistance programs are among the most generous in the country. Pregnant adolescents are eligible for MediCal benefits upon verification of pregnancy, as well as participation in a state-only AFDC program that waives the federal rule limiting AFDC coverage for pregnant women to the period after the third trimester of pregnancy. The maximum award for a family of four is $601, and the maximum Food Stamp allotment is $253 for the same size family. These policies could soon change under Governor Deukmejian's administration.[9]

Maternal and Child Health (MCH)

The Office of Maternal and Child Health (MCH), located within the Department of Community Health Services, has focused some attention on pregnant and parenting teens. MCH is the single state agency responsible for health programs for pregnant and postpartum women and children

under one year of age. Current emphasis is on perinatal regionalization programs that the agency hopes will decrease perinatal mortality and morbidity and reduce the cost of the delivery of maternity and newborn care services. The Office controls only a limited amount of discretionary funds due to the strong control exercised by county Health Departments in California. In addition, early implementation of the MCH block grant has seen the Office continue the funding of most local projects that were receiving "pass through" grants directly from the federal government. Nonetheless, the state is planning to concentrate some categorical aid with a particular emphasis on preventing adolescent pregnancy. MCH has for the past three years convened a state-level task force on adolescent pregnancy. This task force meets regularly to share information and plan advocacy for affecting state policies relevant to pregnant adolescents. Their current emphasis is to develop better standards for community perinatal care, especially services for adolescents.

When California accepted the MCH block grant money consolidated by the Omnibus Budget Reconciliation Act of 1981 for the state fiscal year 1983, it continued all three local recipients of Title VI OAPP funding at their former levels. In state fiscal year 1984, one of the three providers was dropped by the state from its adolescent pregnancy contract; the other two in Los Angeles and San Francisco were continued.

"Jobs Bill" money made available as a countercyclical federal aid program in fiscal years 1983 and 1984 has not been set aside for MCH in California. According to state officials, California was the only state receiving this aid that did not set aside funds for maternal and child health. Instead, most, if not all, of this money will go to Crippled Children's Services. Some state officials believe that the growth of the Crippled Children's program is due to heavy middle-class support; eligibility for participation is very broad (the income ceiling is $40,000).

Family Planning

According to the state Director of the Office of Family Planning (OFP), the Department offers a "traditional services approach to contraceptive service delivery and information and education programs." The Office of Family Planning has in recent years funded about 75 local service programs per year (at about $30 million); none of this is specifically targeted to teens. However, local providers may, at their

discretion, design special programs for adolescents. Because of federal and state cuts, the OFP budget was reduced by 25 percent for fiscal year 1983.

Interestingly, Family Planning (rather than the DOE) awards contracts for family life education programs to public schools and private family planning providers. The Department has been criticized by some groups for executing these contracts. In fact, the Women's Commission for Responsible Government, a conservative advocacy group, has filed suit against OFP's right to fund programs that target unmarried students in school. Although OFP does not itself fund abortion services, the agency has come under attack for funding agencies that counsel abortion. There is no state proscription of this policy. In fact, state-funded abortions are currently provided for under MediCal, although Governor Deukmejian has threatened to terminate them.

Social Services

Discretionary funds for social services are in short supply. Title XX-funded day care and other social services do, no doubt, serve some adolescents who are pregnant and parenting. One source of innovative programming that has relevance to parenting teens is the new Child Abuse Prevention Services (AB 1733), enacted in 1983. It is funded at nearly $10 million for the current year and supports over two dozen local projects.

Interagency Coordination

Teenage pregnancy is of interest to several California state agencies, but there is little evidence of interagency coordination administratively or fiscally. State officials are aware of this fact. As a health official said, "One frustration I have is the lack of interface we have with DOE. I guess we haven't had the initiative to do so yet. It's real necessary." This official, along with many other state bureaucrats and legislative staff, have tried to coordinate efforts in the past years, but with little success.

As early as 1977, two senior state officials had organized a "children's circle" group whose goal was to "become an interagency council on children." By 1978, this group's attention turned to teenage pregnancy. Eleven state agencies, several legislators (including the Chairman of the House Ways and Means Committee and the Mayor of Los

Angeles), service providers, and other prominent citizens comprised a steering committee to promote a coordinated state-level, school-age pregnancy prevention program. State hearings conducted by the Senate Select Committee on Children and Youth in July 1978 focused attention on the dearth of services for pregnant and parenting teens. A context for state action was in place. Negotiations with federal officials for Title VI coordination funding took place. However, the coalition failed when the Department of Education would not agree to the approach. Apparently, the programs were to be administered by the Office of Family Planning and were to combine emphases on family life education, family planning, and information and referral. DOE refused to sign off, leaving a legacy of ill will that persists. For example, one health official reported that in the five years since the demise of the task force, he had not had a single conversation with his Department of Education counterpart. "The problem," he said, "is simply turf."

Interagency efforts to coordinate services have been constrained by lack of political support. One senior legislative analyst told us that former Governor Brown was not enthusiastic about the potential for interagency networking. He told her, "It's boring, it doesn't sing."

Governor's Advisory Committee on Child Development

Since 1965, there has been an interagency group called the Governor's Advisory Committee on Child Development (GACCD) which conducts studies and recommends general policies that have an impact on children and families. The group of 25 (20 appointed by the governor and five by state agencies) meets monthly. Recently, the GACCD has focused on child care for young families enrolled in Job Training Partnership Act programs. The Committee has recently been funded by the federal Office of Human Development Services for a study entitled: "New Partnerships to Meet the Child Care Needs of Low Income Families." This study, combined with legislation that mandates that child care services be paid by JTPA employer participants, may presumably benefit some teenage parents.

Legislative Interest

Efforts to promote increased services for pregnant and parenting teens are currently stalled because of the budget crisis and the current administration's priorities. Nevertheless, there have been some interesting developments.

SB 1090. SB 1090, introduced in 1983 by state Senator Gary Hart, attempted to strengthen school attendance requirements for pregnant and parenting teens. The bill would require, as a condition of AFDC eligibility, that pregnant minors be referred to a school guidance counselor or principal for development of an educational plan. The content of the plan would include prenatal care, counseling, transportation, relevant coursework, and nutritional lunches. The legislation was conditioned on a federal waiver permitting the Department of Social Services to require that a minor mother defined as "caretaker relative" be enrolled in a high school in order to receive aid. This legislation attempted to reconcile mandatory school attendance for all persons under 18 years of age with federal welfare regulations that prohibit the conditioning of grants for family heads with children under age six. (State regulations for the state-only AFDC program for minor caretakers currently have no work or education requirements as a condition of eligibility.) The legislation, despite its strong support from the California Alliance Concerned with School-Age Parents (CACSAP), never made it out of the Finance Committee.

Assembly Bill 1162. As previously noted the Governor's Advisory Committee on Child Development (GACCD) assisted in drafting legislation to provide additional child care through the Job Training and Partnership Act (JTPA). AB 1162 established a Child Care and Employment Act to provide child care services for children of participants in JTPA by providing for a child care and employment fund in every service delivery area. Funding is provided by JTPA (one-quarter) and a Title XX (three-quarters) Department of Social Services match. The legislation was enacted and $6 million from DSS was to be transferred to the State Department of Education which administers child care programs.

Block Grants. Various proposals have been offered by Governor Deukmejian to limit state control of local programs. The "mega-block grant" approach would consolidate state-level categorical programs and permit counties to use the funds at their discretion. It was defeated by the legislature in 1983. Some advocates for teenage pregnancy services would not oppose reorganizing state government; several expressed enthusiasm for removing OCD from its lead role. However, many fear that the loss of state administrative oversight would result in even greater service inequities at the local level.

State Organizations and Lobbying Efforts

CACSAP is one of the oldest and most active state advocacy and lobbying organizations for school-age parents in the country. Founded in 1971, it has as its objectives:

1. To provide and exchange information on new developments and pending legislation in the areas of adolescent sexuality, teen pregnancy, and parenting.

2. To influence state and local decisionmakers in the areas of education, social, and medical services.

3. To provide consultation and disseminate information on existing and proposed programs for pregnant minors and school-age parents.

4. To provide a support network among agencies and/or professionals working with teen parents.

5. To stimulate social action on behalf of school-age parents and their children.[10]

CACSAP publishes two quarterly newsletters, one for California and the other for a western regional coalition of state groups called Teenage Pregnancy and Parents Western Regional Education Committee (TAPPWREC). CACSAP's current president and vice president serve on a Senate Advisory Committee on Parenting Education which has had as its major goal the mandating of parenting education over the past several years. While many believe that CACSAP is an important force in promoting legislative interest, one state official deemed the group "singularly ineffective." CACSAP's most recent efforts have been to support Senator Hart's bill to strengthen school attendance requirements and to encourage OCD to improve monitoring of pregnant minor programs.

One individual identified as having had a critical role in supporting services for school-age parents, is a self-appointed "volunteer advocate for children." This person, a lawyer, lobbies the legislature for increased funding for the SAPID program, and works with CACSAP and others interested in school-age parenthood. He has collected data on the need and costs and benefits of services. Office of Child Development staff and CACSAP representatives cited his efforts as having significant influence with the legislature.

Conclusions

California is a national leader in programs for pregnant and parenting teenagers. It has developed two school-based models that potentially promote the development of comprehensive services. Unfortunately, the burdens associated with administering the state's special day care programs in a time of severe fiscal stress seem to have overwhelmed OCD. The state's Pregnant Minor Program has no administrative home; local school districts are currently using the special set-aside funding to meet general revenue shortfalls. The SAPID program, after expanding through 1980, has been placed on hold. New programs in areas with demonstrated need cannot receive state SAPID funding unless other programs are terminated.

The distribution plan for both state-funded programs (SAPID and PMP) rewards communities with a history of innovative programming at the expense of less advantaged localities. If the Office of Child Development maintains administrative control of both SAPID and the PMP, it should consider ways to facilitate the merger of the two programs for those school districts that wish to do so. Many of the state's most comprehensive programs have already found ways to execute "de facto" mergers; this process could be made easier.

Efforts to involve other state agencies in jointly solving problems associated with teenage pregnancy and parenthood have failed. A significant rift exists between the Departments of Education and Health over the responsibility each should have for this population. Furthermore, policies that focus exclusively on the school population risk neglecting the many youngsters who have already dropped out.

II. FRESNO

Located in the heart of the San Joaquin Valley in central California, Fresno is perhaps best know as a major agricultural center. Over $2 billion in agri-business is conducted in Fresno County annually. The city, with a 1980 population of 217,289 is the only major urban area within 100 miles. It is the trade center for six rural, agricultural counties to the north and south.

Fresno has nearly doubled in population in the past 20 years, and its growth since 1970 has been particularly rapid. Fresno's minority populations are growing with Hispanics now representing 25 percent and blacks 10 percent. Large numbers of Asians have recently settled in the city (especially Hmong from Laos and Cambodia). Fresno's Armenian population is the state's largest. Many migrant farm workers, predominantly Hispanic, have begun to settle permanently in Fresno. As agricultural work has become less labor intensive, many have attempted to find work in Fresno's growing service industries. With the labor market unable to accomodate fully the growing pool of available workers, unemployment has been on the rise.

Nearly one-fourth of the city's work force is employed in professional/technical jobs, many of them in the public sector. Fresno is the county seat; it is also the site of the Internal Revenue Service's western regional office. In the 1982-83 school year, the Fresno Unified School District (FUSD) passed Oakland to become the fourth largest in the California system. There are over 52,000 students in the public schools, which included 53 elementary, ten middle, six high schools, and seven continuation schools.

As the city has grown, it has acquired many big city problems. Most of the city public schools are poorly integrated, affordable housing for the city's lower and middle classes is scarce, and the city's standard of living is falling compared to others in the state. The median income for Fresno is considerably below the state's average, and a much higher percentage of its citizens fall below the poverty line (12.8 percent of Fresno's population compared to 8.7 percent for the state). The number and rate of adolescent pregnancies are among the highest in the state.

In 1984, a State University of New York geographer rated Fresno lowest in a group of 277 cities compared on a number of quality of life dimensions including economics, climate, crime, and housing.[11] Our examination of Fresno's programs for pregnant and parenting adolescents suggests that this negative assessment neglects one of the city's most precious resources. Fresno provides evidence that a community can constructively address major problems through collaborative effort.

Service Climate

The Fresno social service climate is supportive of programs for pregnant and parenting teenagers. In large part, this is due to the impact of a community planning mechanism called the Fresno Interagency Committee (IAC). The IAC provides an outstanding example of how coordination can improve the efficiency and quality of programs. Of the ten study cities, Fresno relies the most on interagency collaboration as a mechanism for solving a wide variety of youth-oriented social problems.

The IAC, begun in 1977, has two sub-committees and an at-large membership comprised of over three dozen agencies that serve children and youth. The policymaking board, "Sub-Committee A," consists of the senior administrators of 12 public agencies: the county's administrative office, Department of Social Services, the district attorney, Health Department, Juvenile Court, Office of Education, Probation Department, public defender, Sheriff's Department, Police Department, the Fresno Unified School District, and the Valley Medical Center. This group meets monthly as a policymaking body. It forges interorganizational agreements, and acts as a troubleshooter for system conflicts. It also directs the work of an Interagency Coordinator who staffs task forces on selected issues. Sub-Committee B is comprised of other commissions and organizations serving youth that share information and provide feedback to Sub-Committee A. The at-large membership helps identify and prioritize new issues for IAC attention.

Perhaps the most significant actor in motivating and validating the work of the IAC is the presiding Judge of the Fresno Juvenile Court. The absence of such a neutral arbiter to reconcile agency differences has contributed to the failure of attempts to coordinate agency efforts in other communities. IAC has succeeded because of the work of its staff and the committed leadership from each of the five

successive Juvenile Court Judges who convene the meetings of both the policymaking and advisory committees. According to an IAC description, the advantages of having a judge serve as Interagency Convener are these:

- o the Court is neutral;
- o the Court is never in the position of competing with an agency for staff positions or dollars for a particular program;
- o the Court has more inherent and perceived power than the other agencies; and
- o the Juvenile Court Judgeship changes often enough to avoid the imprint of one personality year after year.[12]

It is hard to quantify the impact IAC has on the Fresno service climate. Certainly, many of the most effective programs (see service description below) have either been initiated or improved as a result of its planning. The IAC is not an implementer; the agencies retain that responsibility. The IAC serves as a catalyst for improving problem recognition, increasing involvement, and advocating solutions. It has addressed a number of issues that cut across disciplinary boundaries--child abuse, gang violence, school drop-outs, teenage parenting, refugee resettlement, and status offenses. The county-wide social service program for pregnant teenagers (Resources and Education for Adolescent Parents, described below) is a direct outgrowth of the IAC process.

Conservatives, moderates, and liberals have come to value the effectiveness of the collaborative process in planning and implementing services. Since the agencies represented on the IAC have four separately elected governing authorities, there exists broad institutional and citizen support for its work.

Historical Development of Services to Pregnant and Parenting Teenagers

Fresno has been committed to special services for the pregnant and parenting teenage population for a relatively short time. Most of its comprehensive service components have been developed during the past five years. Several of these programs are unique in both their content and their structure. The most impressive aspect of Fresno's service

development has been the ability to expand program coverage during a time when resources were scarce.

About 20 years ago, a special component for teaching Child Development and Parenting was prepared by the school district's home economics coordinator. This woman later led the fight for programs for pregnant and parenting teens. She organized a group of social service providers, community volunteers, and school personnel that advocated special infant care centers on two high school campuses where pregnancy-related drop-outs were especially pronounced. The Board of Education approved the plan contingent upon securing funds. An Ad Hoc Community Advisory Committee, under the leadership of the home economics coordinator, approached the Model Cities Neighborhood Councils for money. Although all six Neighborhood Councils approved the project, administrative barriers blocked the receipt of program funding.

By 1972, Fresno had received special pilot HEW funds to develop an "Exploring Childhood" curriculum. Roosevelt High School was selected as one of 200 schools in the nation to test this parenting skills curriculum. While seeking other sources of funding for the proposed infant centers, the "Exploring Childhood" classes were continued as home economics electives. In March 1973, Vocational Education funds for disadvantaged students were obtained to start day care centers at two high schools and to provide instructional laboratories for students who wished to train to become child care aides. In 1974, due in part to state lobbying by the Ad Hoc Advisory Committee, the SAPID legislation was passed. Fresno, one of the state's first-year pilot projects, used its funds to expand its two programs. A third SAPID center was opened in 1975, and the fourth and fifth centers opened in 1978 and 1982. The school district continued to use Vocational Education dollars to augment the "Exploring Childhood" curriculum studies with a laboratory training component. As a result, many students were able to receive Child Care Attendant certification upon high school graduation.

During the decade between 1972 and 1982, the district used Pregnant Minor Program (PMP) and SAPID funds to develop an integrated, school-based program for pregnant and parenting students. The primary emphasis was to keep students in school, particularly after delivery. Special arrangements were made at DeWolf Continuation School to accommodate most of the younger pregnant students who would

not be eligible for high school credits in the comprehensive high schools. Historically, efforts have been made to mainstream students into the larger student body when educationally feasible while providing special services through on-site SAPID day care and training centers (called PACE).

Other Services

Fresno's emphasis on parenting education had led to the development of several other services to pregnant and parenting teenagers. In August 1978, the Board of Education, under the leadership of its woman president (who later became the coordinator of the IAC), mandated parenting education for all seniors as a high school graduation requirement. The curriculum was based on the "Personal and Social Living" course developed earlier by the Home Economics Department. The community did not mandate the program for students in the lower high school grades, and many advocates of prevention considered this a setback.

In late 1978, the Fresno Community Council (another important planning resource) convened a Task Force on Teenage Pregnancy in response to "the alarming increase of unintended teenage pregnancies in Fresno County."[13] The Task Force was comprised of 50 agency representatives, as well as concerned citizens. Three goals were identified: to promote community awareness of the problem; to equip parents, teenagers, and professionals with the information and skills necessary to promote healthy sexual decisions among teens; and, to encourage better coordination and use of services by teenagers while identifying service gaps. The Council sponsored community forums, developed workshop materials, and focused media attention on teenage pregnancy. It also worked on a statistical fact sheet documenting the growing numbers of adolescents who were becoming pregnant, dropping out of school, or having abortions. The Council also placed the issue on the agenda of the Interagency Committee.

When the IAC chose "parenting" as an issue warranting community attention in February 1979, it did so as a result of a consensus that deficient family communication and a lack of sex education were contributing to a host of adolescent problems. Issues such as child abuse, juvenile delinquency, and teenage pregnancy were linked together in the IAC's deliberations. Beginning in May 1979, an IAC Task Force staffed by the Council on Child Abuse Prevention (CCAP) conducted a

needs assessment (under the direction of the California State School of Professional Psychology), to determine what services were lacking and what program models might work best to improve the parenting capacities of Fresno families. The Task Force determined that pregnant and parenting teenagers were the population most in need of improved services. The most pressing needs were identified as preventive approaches "via parenting education at younger age levels" and the "coordination of community effort in dealing with the development and provision of services to teens." The Task Force also called for more vocational training and "pull-out" school programs, ones which would remove 12 to 15-year old pregnant teenagers from regular classes for special instruction.[14]

Community efforts to improve services to pregnant and parenting teenagers have been significant. In June 1981, the Department of Social Services (DSS) began organizing a special Resources and Education for Adolescent Parents (REAP) project. The Department created a focus group of line, supervisory, and administrative staff from its service and eligibility divisions. The woman who chaired the IAC Task Force was a significant driving force in this effort. This group developed the special intake and referral functions that characterize the REAP approach. The emphasis (detailed below) was to coordinate the efforts of eligibility and social workers who had contact with pregnant and parenting teenagers, and to provide a "one-stop" entry to the service system. Adolescents had been getting lost in the bureaucratic maze because available services were not identified and utilized. The REAP Task Force also began preparing a community resource guide for pregnant and parenting teens and their families, and a monthly newsletter to teenage parents for outreach, education, and informational purposes. It convened a broad-based advisory board now known as the REAP Congress, made up of representatives from 17 county agencies involved with teenage pregnancy.

Also during 1981, a state pilot project, "The Family Communication Program," was funded for the Fresno area by the Office of Family Planning. The program, which was cut back by the current administration, attempted to improve parent-child communication about teenage sexuality and pregnancy risks by extensive educational campaigns in the media, at community forums, through religious groups, in hospitals and physician's offices, and in dozens of other community-based organizations. A special "Family Communication Week" was held and workshops for parents were given by community groups.

Finally, in 1981, the director of the SAPID programs attempted to expand the schools' services for younger pregnant and parenting teenagers by proposing a satellite program at DeWolf Continuation School. A program was funded for 1982 which allows younger teenagers to take classes at their own grade level while receiving special prenatal and postpartum instruction.

Current Services to Pregnant and Parenting Teenagers

Comprehensive services in Fresno are achieved by the coordination of the school-based and DSS special programs, and the linkage agreements with many area providers. The services are still in a less developed stage than some of the other comprehensive sites because of the recent start many agencies had in addressing this issue. Because the emphasis within the comprehensive high schools is to mainstream both pregnant and parenting students, it is somewhat more difficult to assess whether such students are receiving services they need.

PACE. The Fresno Unified School District (FUSD) combines four separate funding sources to provide its services. Funding for the combined program, called PACE, was $487,000 in 1982-83. This included the largest single state SAPID allotment ($277,000); approximately $80,000 in local district contribution for teacher salaries; $120,000 in PMP reimbursements; and $10,000 for the vocation education child care training program.

When a teenager becomes pregnant in Fresno, she has several educational options. Among the minority who stay in school (a DSS representative told us that approximately 80 percent drop out), most choose to stay in their high school and participate in the SAPID program. Four of the six comprehensive high schools have SAPID programs, and one Continuation School, DeWolf, has a combined PMP/SAPID program. The student may transfer to DeWolf or, if space permits, the nearest school with a SAPID program. (Waiting lists are periodically started at each program.) Students are made aware of the available services by school counselors, extensive advertising within the school, referrals by DSS, and through word of mouth.

A pregnant student entering one of the four comprehensive school-based SAPIDs is examined by a school nurse who establishes whether she is receiving prenatal care and makes other appropriate referrals. In addition to the regular

academic curriculum, the student joins a special group that takes classes, taught by the nurse, in prenatal care and childbirth preparation. She is also enrolled in a parenting education course, either with other pregnant and parenting students or in a mixed setting. (One high school emphasizes separate instruction.) Students may choose from several courses including "Exploring Childhood" and "Personal and Social Living." The pregnant student is also required to participate in a daily one hour laboratory session at the infant care center itself. A student who had already delivered receives the same services with a few modifications. Her child is screened for health status, and she gets special one-on-one instruction with her own child in the SAPID lab.

All SAPID enrollees and their children are given free breakfast, lunch, and supplementary food. (Infant formula is also given.) Transportation is provided directly by FUSD only if the student lives a sufficient distance from school to be part of a regular bussing program; otherwise, students receive city bus tokens. A special vocational program is also available to all SAPID enrollees (which includes students who are neither pregnant nor parenting since the program regulations specify participation is open to all students), in which they can receive certification as child care aides after completing requisite training. When students are not participating in lab programs or attending parenting classes, they are enrolled in regular classes. Also offered are extensive links with other Fresno providers by way of classroom demonstrations. A number of agencies, including Planned Parenthood and the county Health and Social Services Departments, visit the programs frequently.

The PMP/SAPID program based at DeWolf differs in some respects from the four integrated SAPID centers. First, far more pregnant students are enrolled at DeWolf, which is the only school with the capacity to offer course credit to students below the ninth grade level. During the regular year, the DeWolf program normally has three times as many pregnant students enrolled as the SAPID-only programs. Second, pregnant and parenting students at DeWolf are a separate group on campus. Although they take math, English, and other academic courses with other students, they attend prenatal and parenting classes together in the same period of every day. Third, some specialized tutoring is emphasized for the younger students enrolled in the program. Finally, the program has its own administrative home, and the principal of DeWolf is in charge. Students enrolled in SAPID mainstream programs may not be counted as "pregnant minors" because both SAPID and PMP have an ADA

reimbursement formula component. Since the district must avoid double counting, the administration chooses to receive the higher SAPID reimbursements. Over the years, the PMP often has been used as a safety valve. It has been a separate program for those students wishing to remove themselves from the comprehensive campus, and it now serves as an overflow school for those on waiting lists for the SAPID program at other schools.

The programs vary in enrollment from 33 to 65. All together 289 pregnant and parenting teenagers were enrolled in PMP or SAPID programs in 1982-83.[15] In addition, 220 student without children worked in the SAPID labs, and 190 infants and toddlers were served in the SAPID centers. Any student enrolled in the FUSD is eligible for these services, but participation by males is minimal.

In each SAPID program, the district employs a teacher/-director, a lead teacher (or teachers), full-time instructional aides, and a food preparer. Volunteers, teenage parents and trainees also contribute to the operation. A part-time child psychologist serves as a program consultant and regularly meets with teachers for in-service sessions and with the students, but offers no direct services. Two nurses perform intake and referral functions and one is available approximately ten hours per week in each site. The overall program is administered by the coordinator of Home Economics for the district. It does not operate over the summer months.

Pregnant students have been followed for the past five years in an effort to demonstrate the programs' impact. Summary statistics on the numbers served, by age group and location, are prepared. In addition, the report profiles the progress of students after they graduate, collecting data such as what percentage go to college, secure employment, or have additional children. This type of evaluation is used less to improve the program functioning than to demonstrate the benefits of the program to the community.

REAP. The Department of Social Services Resources and Education for Adolescent Parents (REAP) program has grown rapidly since its inception in March 1982. The REAP project provides a comprehensive range of services to Fresno County adolescent clients who either demonstrate a need for such services (i.e., protective services) or voluntarily request help. The project consists of: 1) a specialized Teen Age Parent (TAP) Eligibility Unit which provides both intake and ongoing financial assistance services; 2) a specialized unit of

Teen Age Parent (TAP) social workers which provides core services to adolescents referred by the TAP eligibility Unit or community agencies; 3) the REAP Task Force, a DSS planning, training, and monitoring group that meets monthly; and 4) the REAP Congress, a coordinating and training group of representatives from 17 community agencies that serve adolescents.

Eligibility workers have devised special intake procedures for teenagers. Income assistance and special one-month MediCal stickers for family planning services are organized so as to minimize the number of bureaucratic encounters the teenager has. One eligibility worker explained, "They have ten minute bottoms. In ten minutes, they're ready to go." TAP social workers perform services which "help to alleviate and reduce the health, educational, and social risks surrounding teenage pregnancy."[16] The TAP social workers develop a client case plan and offer counseling for TAP clients and their families. They provide direct assistance with information and referral on available community resources, meeting economic needs, infant care, legal rights and responsibilities, obtaining education on home management, and independent living skills.

In order to meet the goal of providing a central intake and referral system for all Fresno County pregnant and parenting teenagers, the project coordinator performs extensive outreach and networking functions. A community advisory board helps in this process. The coordinator also conducts workshops, distributes a resource directory, and develops educational mailings for REAP participants. This coordinator also has successfully written grant proposals to extend the coverage of the REAP services, having most recently received child abuse prevention funding from a new state initiative.

In addition to eligibility workers who perform intake and screening procedures, the TAP unit now employs four full-time social workers and a half-time supervisor. The Department carries an average of 550 "teenage" cases at any one time and is now referring 75 per month for "special social work services" to the TAP workers. The DSS keeps statistics on the number of clients enrolled in school and actively encourages re-enrollment in the SAPID program or in Project Re-Start, a transitional program serving 32 students who have been out of school for a short period of time. (Re-Start meets in a church and provides special tutoring, parenting education, and day care services to help students reacclimate themselves to school.)

The program in 1983 served a clientele that was 61 percent Hispanic, 22 percent white, and 16 percent black. The REAP Task Force is now investigating ways to encourage males to use their special services.

Health Services. Health services for pregnant adolescents are scarce in Fresno. Most teenagers living in Fresno deliver at Valley Medical Center. Last year a special teenage clinic was established there for adolescents aged 16 and under. The clinic operates for three hours once a month during which time the teenager is examined by an obstetrician, has the opportunity to speak individually with a hospital social worker, and attends group discussions and presentations by area providers. At this writing, the clinic is seeking funds to expand its caseload which now averages 20 per month.

The Women's Health Center (WHC) and the local Planned Parenthood (PP) affiliate provide clinic services directed at teenagers. The WHC uses public health nurses for special counseling while the PP relies on trained volunteers. Both organizations provide free pregnancy tests to teenagers and make presentations in schools and other community settings. The PP has a telephone hot-line which is heavily used by teenagers; the service attracted over 2,000 calls from teenagers in the last year. Other health services for teenagers include a WIC program at the Community Health Center and a County Health Department family planning unit. Special one-month MediCal stickers for family planning services are distributed to teens through the REAP program. Two clinics perform abortion services in Fresno, but several respondents indicated that no satisfactory abortion counseling exists at these programs or elsewhere. Most, if not all, area health providers accept MediCal.

Other community resources used by pregnant and parenting teenagers include a special health program for juvenile offenders based at a correctional school serving about 20 pregnant teenagers per year; four school district state-funded day care centers which give priority to SAPID graduates; and a group home administered by the Children's Home Society (CHS) which has space for six pregnant adolescents at a time. CHS also offers adoption counseling and makes presentations in many schools.

Factors Enabling and Hindering the Development of Services

Resources. Fresno's most important resource is its ability to plan and follow through on service development. Fresno service providers are community-oriented; they live in the city themselves and have worked together for a long time.

The Interagency Committee is perhaps the most effective and powerful force in the Fresno social service community. The participation of so many agencies and top officials gives it legitimacy; the persuasive and neutral nature of the judge-convener gives it implementing power. The media cover the progress of the IAC and a constructive competition exists among the members to develop new problem-solving strategies. The IAC contributes to community pride; those responsible for it know it is unique. They are often contacted by other communities that wish to replicate its operation.

The tone set by the IAC permeates the service structure throughout Fresno. Turf struggles appear minimal, bureaucrats seem committed to agency coordination. An ideology has been adopted that seems well suited to resource-scarce times. Duplication of effort is minimized and area providers use this knowledge when they apply for funds. This coordinated approach has attracted additional funding. Also, the coordination focus at the interagency level has sensitized top administrators to the needs of their supervisory and line staff. The flexibility of the DSS administration is reflected in the speed with which the REAP program was organized and implemented.

The Fresno service structure is dominated by leaders who have commited their careers to improved programs. Every program planner or administrator to whom we talked had been working in Fresno for at least five years, most for over ten. These individuals are very skilled in finding support. They tap multiple funding sources (e.g., PACE, REAP); quantify the impact of their services with studies and fact sheets demonstrating the long term costs of not serving pregnant teenagers; and use volunteers to deliver services. The emphasis on coalition building has been used to diffuse opposition by inviting dissenters to serve on study committees to review service approaches.

The media are active and supportive of community projects. One radio station was recently honored by the Corporation for Public Broadcasting for "outstanding achievement in local public participation." One respondent

described the city's newspaper as "open-minded and accessible...a God-send in terms of its parenting coverage."

Other groups have organized, often on an ad hoc basis, to fight budget cuts and lobby the city council, often using the media. In 1982, a group of community-based organizations succeeded in blocking a council decision to limit city funding of their services by waging a vigorous public campaign.

There are other indications in the community that minority and women's issues are considered important. The city recently shifted from an at-large to a district election model for its city council and school boards, thereby increasing the ethnic diversity of those bodies. Three of the five school board members, including the president, are women, as is the coordinator of the IAC. Women have spearheaded the movement for special services for pregnant and parenting teenagers in Fresno.

Constraints. The biggest obstacle to service development in Fresno is the growth of the population in need. Fresno has also encountered difficulty in organizing its health care system to meet the needs of pregnant teenagers. The special program at Valley Medical is quite small and other hospitals have not actively expanded coverage. Family planning services, including birth control information and education, have been severely cut. The Planned Parenthood education budget alone has been reduced 80 percent over the past several years. Although programs in child abuse prevention and parenting education have received support, some providers believe that the health system must take a more active role in developing both preventive and care services for pregnant adolescents.

Programs for pregnant and parenting teenagers remain controversial when linked with sex education. Groups such as one called Parents Against Raw Sex, have raised concern over textbook content and a state-inspired health education curriculum handbook. The ongoing battle over Parenting Education at lower grade levels is evidence of the difficulty the schools have had in designing preventive programs. Administrators also face criticism from teachers, principals, and parents who are not supportive of the mainstreaming concept of the SAPID program. One administrator told us that the program is too visible, and some school officials question the SAPID centers.

Conclusions

Fresno is now providing comprehensive services to pregnant and parenting students by combining two service models. The combined PMP/SAPID program shows a unique use of resources, but falls short of its comprehensive service goals because of its limited penetration rate and its inability to address the special needs of younger adolescents. The Fresno community is experiencing rapid growth which creates new demands for services which are more difficult to meet in an era of diminished support. Planning mechanisms such as the IAC and the Fresno Community Council have been productive, and the climate for developing services is quite supportive.

The REAP program, based in the local public welfare department, is a model of how much can be accomplished with an affirmative approach and limited resources. It stands in sharp contrast to some other local welfare departments that offered no special help to adolescents or placed informal barriers to their access to public benefits.

Fresno is also unusual in that the PACE program maintains good summary statistics on program participants, including follow-up data where available on their post-program experience. The data are used primarily, however, to generate community support rather than assess program effectiveness. There is no comparison with non-participants, for example, nor any pre and post-testing of participants.

The Fresno case also illustrates many of the principal conclusions common to other localities as well:

State funding, in this case for the SAPID and PMP programs, while no guarantor of successful program development, can provide the core upon which a comprehensive program may be constructed.

Effective service coordination requires both an authoritative sanction and staff resources, as were provided by the IAC and Fresno Community Council.

Unlike many of the other localities, most local health providers accepted MediCal (i.e., Medicaid) patients. At the same time, the fragmented health delivery system and recent reductions in family planning resources constrained service provision for adolescents.

Even though the Fresno program was highly regarded outside the community, many school personnel were not supportive of it. The opposition to sex education in the schools by a vocal minority, together with the school board's reluctance to undertake controversial initiatives, limited its availability to the oldest students.

The history of program development in Fresno exhibits a gender-based pattern common to every one of the study sites. The need for services was first recognized and promoted by female teachers, social workers, and community activists, who subsequently secured support from predominantly male school, court, health, and social welfare agency administrators.

III. OAKLAND

Oakland has been the site of much study and social experimentation. Its problems are those common to many urban areas. Demographic shifts have weakened the tax base while increasing the demand for services. Between 1970 and 1980, while most other California cities were growing rapidly, Oakland experienced a 6 percent population loss from 362,000 to 339,000 persons. The city's racial composition shifted from 48 percent white and 34 percent black to 45 percent black and 35 percent white. Approximately one-sixth of Oakland's families have incomes below the federal poverty line; unemployment has been more severe in Oakland than elsewhere in California.

A new generation of leadership has emerged in Oakland over the past decade or so. Increasingly, blacks are in policymaking positions, replacing the older, white establishment that governed Oakland in the 1960s and 1970s. The city's major, police chief, and school superintendent are all black, as are the majority of school board members and city counselors. Both the school board and city council have changed from an "at-large" to "district" method of representation.

The city's schools are administratively separate from the city. Prior to Proposition 13, schools could increase property taxes to finance program expansion. This gave school administrators and board members substantial leverage within the city power structure. The post-Proposition 13 era has been painful, of course, as the schools sought ways to integrate their budget deliberations with those of the city. Efforts to finance the city and school budgets become more difficult each year. School Superintendent Bowick told the Wall Street Journal in July 1983 that Oakland was perhaps "the most distressed urban district" in California.[17]

The Oakland Unified School District (OUSD) is the state's fifth largest (though Fresno may surpass it this year). It has an enrollment of some 48,000 students K-12, having fallen from a peak of 65,000 around 1970. The racial composition is approximately 70 percent black, 11 percent Hispanic, and 8 percent Asian. The remainder, about 11 percent, are white. The city has six regular, comprehensive high schools, four "necessary" high schools, and one special K-12 fine arts school. Thirty-seven languages are spoken in the schools.

Integration within the system is very limited, and only one high school is significantly balanced. There is no pressure to integrate the Oakland schools, but open enrollment plans are used to facilitate access to the "schools in the hills" for those blacks and whites who consider them superior.

While Oakland's ability to provide services is precarious, there are dozens of programs and hundreds of providers that are trying. Many are interested in teenage pregnancy and parenting. The need for such services is great; in 1980 alone, more than 900 women under 20 gave birth, and a like number had abortions.[18]

Current Services for Pregnant and Parenting Adolescents

Many special services for pregnant and parenting adolescents exist in Oakland, particularly within the city's school system and community-based health clinics. These services, however are fragmented and uncoordinated. Despite the best efforts of many community providers, the vast majority of pregnant and parenting teens do not receive comprehensive services.

A central focus of many services for pregnant teenagers has been the reduction of the high rates of infant mortality in several areas of Oakland. The Oakland Perinatal Health Project (OPHP), started in 1978, was largely responsible for a community-based health clinic movement in Oakland's neighborhoods. Today, nearly a dozen clinics provide special medical attention for pregnant adolescents in addition to their services for older women. Four of these (East Oakland, West Oakland, Eastern, and the YWCA) are community-based clinics that provide medical care, pregnancy counseling, family planning, and some form of parenting and prenatal education. Two hospital-based clinics (at Highland and Fairmont) are county-operated. Highland has special clinic hours each Wednesday morning for teens and Fairmont has a WIC program available for all income-eligible pregnant women that supplements special teen services offered elsewhere. A third clinic at Children's Hospital recently lost special funds for its teen clinic, but is trying to reestablish services; Alta Bates Hospital serves a disproportionately large teen population in its high risk prenatal clinic and delivery room. In addition, two women's clinics (the Feminist Women's Health Center and La Clinica de la Raza), two branches of Planned Parenthood, a pregnancy consultation center, and a Berkeley MIC program provide services for pregnant teens. Several hospitals and

clinics and one Planned Parenthood branch provide abortion services.

Many of these health care establishments operate on a sliding scale fee basis providing basic prenatal care and education about nutrition, family planning, and parenting. All accept MediCal and none impose any eligibility requirements other than residency. Few employ social work or mental health professionals, although some provide individual and group counseling. Fewer still are able to actively seek out those teens who are not receiving adequate prenatal care or to follow their clients after delivery. The health care system offers pregnant teens an opportunity to receive quality care, but the system is in constant flux. Services change as clinics respond to new demands and funding opportunities, and the health system has been unable to coordinate its efforts in order to increase the number of adolescents receiving special services. The most successful programs in terms of numbers served are the Eastern Health Center (which served over 300 teens last year), the YWC perinatal program (about 100), and Planned Parenthood (about 100).

Paralleling the recent developments in the Oakland health care community has been the growth of school-based services for pregnant and parenting adolescents. Interestingly, these services have been initiated and operated largely by health professionals working within the Oakland Unified School District (OUSD). Both the Cyesis (Pregnant Minor Program) and the Teen Parent Assistance Program (TPAP) operate from school settings, but neither can be characterized as an integrated, mainstream program. Each provides essential services for pregnant and parenting teens, but neither individually nor cooperatively have they yet established themselves as fully comprehensive.

Cyesis

The Cyesis Program has operated in some form since 1949. It currently has three sites in different parts of the city. Two of the locations, Arroyo Viejo and Franklin, are in recreation centers; the third, the Booth Memorial Home, until recently, was also the site of a Salvation Army maternity program for unwed mothers. Each site can serve 40 pregnant adolescents at any one time. Arroyo Viejo and Franklin are each staffed by one full-time teacher, two part-time teachers, and a half-time nurse; the Booth Memorial program by two full-time teachers and a half-time nurse. All pregnant students enrolled in the OUSD are eligible.

Like other Pregnant Minor Programs in California, the goal of the Oakland Cyesis program is to provide transitional educational services to pregnant students. Participants receive instruction in the classes necessary to keep pace with their former classmates including math, English, and science. Attendance requirements are somewhat flexible and attention is given to prenatal health, labor and delivery, and parenting education. Students at Franklin and Arroyo Viejo attend school for the minimum four hours of classroom instruction. Those at Booth tend to be younger (all seventh graders are encouraged to go there, for example) and receive additional classroom instruction. Individualized tutorial assistance and group instruction are offered, depending on the needs of the student body. Few electives are offered.

Upon enrollment, the student is examined by the program nurse and referred to medical providers, and appropriate social service agencies for income support. Students have access to their comprehensive school counselors, but no special social services are provided. Students are also referred to the Teen Parent Assistance Program (TPAP, see below) which offers a wide variety of educational and vocational services. Those enrolled in Cyesis programs normally have no contact with their home schools. Transportation to the program is the responsibility of the student, although the district distributes city transit passes to many. Similarly, transportation between the program and the TPAP and area health providers is the student's responsibility.

After delivery, the student is encouraged to return to her regular school within three weeks, or by the beginning of the next semester at the latest. No day care is provided. As one administrator explained, "The quicker they get back, the more likely it is they will stay." The Cyesis nurse contacts the regular school nurse and guidance counselor, but after that little, if any, follow-up occurs.

The Cyesis program does not operate over the summer months. It is funded, like other PMPs, through ADA formula reimbursements 9 percent above the base rate. Enrollments in the three sites combined have recently averaged approximately 250 pregnant students per year. When we visited the program in October 1983, enrollments were down somewhat because of the closing of the maternity home at Booth Center; all residents had been required to enroll in the Cyesis program there over the past few years.

The Teen Parent Assistance Program (TPAP)

TPAP began in 1981 as a project funded by the Charles Stewart Mott Foundation. The goals of the program are to provide services that allow pregnant and parenting adolescents to remain in school, and to aggressively recruit those who have dropped out. The program's emphasis on outreach, coordination, and networking among service providers reflect a desire to build a comprehensive program. The TPAP has attracted significant support from a variety of public and private auspices and may soon grow into a model comprehensive program.

The current emphasis of the TPAP is teenage parents. Only 20 percent of the clients are pregnant students, many of whom are referred from the Cyesis program. TPAP is labor market-oriented in its approach to teen parents, and many of its services are geared towards the transition from school to work and in adapting student skills to the needs of employers. However, TPAP has had only limited success in this effort. Of 45 enrollees in a 1983 summer employment and training program, 29 graduated, but many of these failed to find jobs.

Besides its special job readiness orientation, the TPAP offers several other service components. Most significant is its emphasis on casefinding through outreach. A half-time attendance/outreach/intake worker networks with the school district and the county Social Service Department to determine which teens have dropped out of school as a result of pregnancy or childbirth. This worker then tries to contact and enroll the woman in TPAP, offering educational and psychosocial counseling, education to complete graduation requirements, and coordination with other service providers. All professional staff other than the director are part time. This includes: the attendance/outreach/intake worker; a three day per week psychologist who does individual and group counseling; a career education and job development specialist who assesses students' basic skills and career potential; a business education teacher who teaches business math and typing; a regular teacher specializing in the basic educational skills necessary for GED or high school graduation; and a part-time consultant responsible for fund raising and program development.

Until September 1983, the TPAP was housed in administrative offices; it did not have a school base. Then, the administrative and instructional components of the program moved to the grounds of Grant High School, a small necessary

school (i.e., a high school offering only those subjects necessary for graduation). Other educationally disadvantaged students attend Grant usually after they have dropped out or been expelled from other schools. Grant's capacity is 150 students, about half of whom come on any given day. The TPAP instructional program is housed in two classrooms--one for required subjects and GED, the other for business-oriented classes. When we visited the program, 22 students were enrolled in the program. All were aged 17 to 19 and none were pregnant. The TPAP attempts to place those 16 and under in the Cyesis program if they are pregnant, and in regular schools if they are parents. Like the Cyesis program, no special transportation arrangements are made by the TPAP. The racial composition of the TPAP services parallels enrollments in the Oakland schools.

The TPAP services are open to any pregnant or parenting student who is 19 or under, has not graduated from high school, and lives within the Oakland school district. (Some job training programs that operate within the TPAP are open to students 21 and under.) The services are open to teenage fathers, though efforts to recruit this population have been minimally successful. The program, before moving to Grant High School, was said to have had contact with "about 270 teens per year, actively serving about 100 at a time." Many of these contacts amounted to "educational counseling" and linking teenagers to available community services. The program has a substantial evaluation contract with the Mott Foundation that covers five years of program operation, but the TPAP service impact on Oakland's pregnant and parenting teens has not yet been ascertained.

In addition to providing services for individual students, the program has developed brochures for both students and professionals, prepared a video tape, participated in radio talk shows, and is conducting in-service training for school staff members and other community service providers. The TPAP produced a directory of health care, family planning, psycho-social, crisis and nutrition services for teens; it also provides a newsletter for teenagers and professionals.

Day Care

Special day care services for teen parents exist in Oakland but they are severely limited relative to demand. The TPAP has specific linkages with two programs, the Oakland Parent Child Care Center and the Peralta Infant Care

Center. The TPAP is currently working with some private foundations to develop a voucher plan that would extend day care to many more teenage mothers.

The Oakland Parent Child Care Center is a special federally-funded Head Start program that has existed in several forms since 1968. Currently, it provides day care for 170 children ages six weeks to three years in the Center, and in a home-based neighborhood program. The Center sets aside 20 slots for children of teenagers aged 13 to 18. Programming for the adolescent parents includes daily one and a half hour morning sessions of parenting education, parent-child interaction, and special group exercises relating to health, social services and child development. Parents return to the Center after classes in their regular schools are completed; transportation is provided to and from the day care center in the mornings. Students receive credit through the TPAP for the classes they take at the Center. Last year, nine of the 20 teenagers graduated from high school. Some go on to enroll in a special job training program in child development while their babies remain at the Center.

The Peralta Infant Care Center is the outgrowth of a federally-funded "Supported Work" project that attempts to provide care and education to 24 teenagers and their children while training a group of unemployed AFDC recipients. Each of the children, aged three weeks to three years, is enrolled in infant day care for six and one half hours per day. The instructor-trainees are welfare recipients, often former teen parents now in their early 30s. These individuals teach the teenage parents in small groups and on a one-to-one basis how to raise their children while coping with the special pressures of young parenthood. At any given time, more than a half-dozen, long-term welfare recipients are in training to qualify as day care instructors. They are supervised by a head teacher. Each teenager is required to spend two hours in child care and development training every week. The program is staffed by two teachers, a full-time director, a social worker (from the county), and, through an agreement with TPAP, a career counselor. There is also a staff medical consultant who does infant health screening and designs nutrition and other postnatal care plans.

To be eligible, teenagers must meet income qualifications or their children must be in protective services. They must also be enrolled in high school or in a job training program, as well as in the TPAP. Opportunities for teenagers to work in the day care center during the summer have been available through Summer Youth Employment Programs. Transportation

is not provided. The program operates through a California Office for Child Development (OCD) general child care grant (not OCD's SAPID program which is specifically targeted to teens), and a Welfare Department diversion grant that allows the AFDC recipient-instructors to receive their welfare checks through the Peralta administration as pay for their training.

Waiting lists for both the Peralta and Parent Child Center programs are very long. Each serves only a very small percentage of those in need of infant day care in Oakland. Other providers, such as the East Oakland Health Alliance and the Oakland Community Child Care Center, have recently lost funding for infant care. No SAPID program exists in Oakland. The school district, which operates 22 child care centers (2,000 slots) for pre-schoolers under OCD's general day care programs, has resisted applying for infant day care monies. School administrators believe that state reimbursements would not fully meet costs, especially in start-up, and that funding for the much more costly infant care might divert resources from other pre-school programs.

The district has also had difficulty organizing community support for mandated sex education. While on paper there exist district sex education guidelines, no formal arrangements for implementation are mandated. As early as the sixth grade, programs are taught by individual teachers and school nurses who receive parental consent. But community, teacher, and administrative support for these efforts has been lukewarm. Providers such as Planned Parenthood are sometimes invited into classes to give presentations; however, these appearances have become less frequent as the length of the school day has been cut back in recent years.

Service Climate

The social service climate in Oakland encourages providers to develop programs that serve small portions of the community very well, while allowing many others to fall through the cracks. However, cooperation through joint ventures, sharing information and referral responsibilities, and the building advocacy coalitions have recently emerged as methods to improve service delivery outcomes. Those interested in developing services for pregnant and parenting teenagers have changed their approach to both obtaining funds and designing programs. Below we examine two new community efforts to serve pregnant teenagers that are indicative of a new approach, but which face significant barriers.

The Booth-YWCA Program

Administrators at the revamped Booth Memorial Center, which recently closed its maternity home, and the Oakland YWCA are currently trying to develop "the most comprehensive program in the country" for pregnant and parenting adolescents. The Booth Center would serve as the case manager or coordinating agency for all of the services, most of which would be available on site. Currently, the Center houses a Cyesis program run by the school district and a child development center funded by the state. The YWCA would be the major provider of medical services to the teenagers, expanding its clinic's capacity. Program components being planned include six general categories:

- medical services (prenatal care, delivery, home visits, well-baby clinic, immunizations, developmental screening and family planning);
- parenting services (childbirth preparation, parenting classes, health education and nutrition, a fatherhood project, pre and postnatal exercises, a parenting resource center, support groups);
- psychosocial services (individual counseling, couples/-family counseling, religious counseling, adoption counseling);
- educational services (Cyesis program, GED and adult education);
- auxiliary services (emergency food and shelter, maternity and baby clothing, new parent survival kits); and
- information and referral (for vocational training, drug treatment, child care, MediCal/AFDC, child abuse and neglect services, primary medical care and legal assistance).

A half dozen community agencies have been contacted and have expressed interest in participating. The Salvation Army (through its own funds and a supplementary United Way grant) has pledged $150,000 to house and support the program, but will not control the administration. The facilities at Booth include a delivery room in which the program hopes to open a free-standing birth clinic with Highland Hospital (a few blocks away) serving as emergency back-up. The administrators plan to initiate some elements of

the program in 1984-85, serving 150 clients that year and gradually phasing in service components over a two-year period.

The success of this joint venture will depend on skillful leadership (a permanent director had not been chosen when we visited), and an improvement in the Booth Center's image. Until the Center closed its residential component in June 1983, many area providers believed that it was "locked in a time warp." The program census was markedly reduced in its last few years and providers feared referring clients because, as one put it, "they never got out once they were in." Until now the Booth Center has been considered outside the "sophisticated" service network.

The program will also face difficulties with its plan for "one-stop" services. The dozen or more community, county and hospital-based health clinics may object to the program. Only two facilities, Highland Hospital and the YWCA prenatal clinic, have been substantially involved. In addition to fears that the Salvation Army might somehow "contaminate" the services, many clinics may simply want to protect their own turf. To its credit, the Army has sought to overcome these obstacles by seeking staff with considerable networking experience in the Oakland perinatal service community.

The International Child Resources Institute (ICRI)

Another newcomer to the teenage pregnancy and parenting field in Oakland is the International Child Resources Institute (ICRI). ICRI plans to use its connections in Scandanavia to bring approaches tested there into the Oakland area. Its program, which began in November 1983, relies on a community-based outreach model. ICRI plans to send its outreach workers directly into the community. In conjunction with neighborhood groups, trained health volunteers will go door-to-door in neighborhoods with high infant mortality rates. They will identify pregnant women, including teenagers, who are receiving inadequate prenatal care and refer them to an appropriate provider, and make sure that the needed services are obtained. To insure the maximum participation of the local communities and management from the "bottom up," ICRI will convene community advisory boards and panels of pregnant and nonpregnant women who will serve as consultants. The program has already attracted widespread interest among funders. First-year funding comes from three foundations, plus one city and one state agency.

Several factors may inhibit the program's success. In addition to the difficulties associated with using volunteer paraprofessionals, community-based coordination may be at odds with the plans of many public decisionmakers. Oakland health providers constantly battle with a state bureaucracy that is interested in promoting perinatal regionalization that focuses on service provision from "the top down." Community-based service advocates have fought vigorously for reduced emphasis on high-cost technical hospital services and more funds for aggressive prevention techniques. Their efforts have met with some success as witnessed by the 1983 passage of Assembly Bill 2821, which supports the development of "community-based perinatal services" in California. But outreach services and prevention programs are underfunded in Oakland, perhaps because other primary care needs are so great.

Cutbacks

The service climate is also unstable due to budget cuts and the preference of the legislature for "demonstration" programs operating in a limited number of locations. Programs come and go and even well-established agencies have had to close. For example, the Family Planning Forum which coordinated the Oakland Perinatal Health Project (OPHP) was recently terminated, and one of the city's two Planned Parenthood branches is contemplating similar action. During its ten-year existence (1973-1983), the Forum was considered especially valuable in providing information and referral services, conducting media campaigns, and coordinating Oakland family planning services. The three-year OPHP demonstration, which began in 1978, spawned many new programs. More than 20 grantees received funds, but most funding disappeared in 1982, causing program closures, mergers, and service reductions.

Historical Development of Services

While some form of special services to pregnant and parenting adolescents has existed in Oakland since the late 1940s, interest has been more focused since the late 1970s. At that time, a well-orchestrated effort by the health provider community and the Oakland news media focused attention on high infant mortality rates and the risks teenagers and other women faced if they did not receive adequate prenatal care. In a now famous press conference called by the director of one of the community-based health

clinics in 1976, providers got the message across. Oakland's infant mortality rates were the second highest in the country (Washington, D.C. was the highest), and in some neighborhoods, they were as high as those in third world countries. In the weeks and months that followed, the media proclaimed that something had to be done to stop "black babies from dying in East Oakland." The advocacy effort was aided by the selective reporting of infant mortality rates that would make the greatest impact.

The result of the publicity and advocacy was the "discovery of Oakland" by Governor Jerry Brown in 1978. In August of that year, the Governor directed the Department of Health Services (DHS) to develop a perinatal health project serving the high risk areas of Oakland and Ashland. The Governor proposed spending $4.5 million on a three-year project from existing (DHS) program dollars. At that time, over 60 percent of those living within the Oakland area received late prenatal care; about 900 of these mothers were under the age of 20.[19]

Funding first became available in late September 1978. Monies were identified from federal Title II of the Elementary and Secondary Education Act and Title V, Maternal and Child Health of the Social Security Act, and from the state Office of Family Planning (primarily through Title X and XX funds). During the first fiscal year, six projects were funded. Due to start-up difficulties, only a small portion of funds authorized for expenditure in fiscal '79 were used. About $500,000 Title II money was carried over, but another $500,000 of unexpended Title V and Family Planning monies were reverted. In the next two years over $3 million was awarded to over 30 grantees. Project management changed hands twice before the Family Planning and Reproductive Health Forum took charge in Fiscal '81.

After the project ended (it was extended through fiscal '82 because of its late start), the Forum remained as the coordinating agency for several of the OPHP grantees. Many projects found new sources of funding or were continued under general program accounts in MCH and OFP. Money for evaluation and coordination, however, soon dried up. The Forum was forced to close down and some statistical reports examining the long-range impact of OPHP were never compiled. Preliminary, but inconclusive, evaluations showed some improvements in infant mortality and client education.[20] Later reports comparing the outcomes of experimental and control groups indicated positive results in terms of birthweight and infant mortality for those enrolled in special

services.[21] Some coordination of services and lobbying for the distribution of state funds is now performed by the East Bay Perinatal Council, a group comprised of 18 city, county, and state administrators.

TPAP. The Teen Parent Assistance Program (TPAP) has its funding roots in the OPHP. During fiscal 1980 (OPHP's second year), the Oakland Unified School District (OUSD) negotiated a cooperative grant from the Mott Foundation and OPHP to perform a needs assessment on student utilization of perinatal services. This assessment was facilitated by the current director of the TPAP who had already studied the problems of teen pregnancy in her role as a school nurse. As early as 1975, she and some colleagues developed special family life education classes and noon rap sessions at Fremont High School which had a high pregnancy rate. She also served as a nurse in the Cyesis program; when OPHP began functioning, she was in search of special funding to address problems associated with teenage pregnancy and parenthood.

By combining the Mott and OPHP grants, the OUSD was able to conduct interviews with 162 pregnant or parenting adolescents about their needs.

After compiling the data, TPAP determined its project goals and objectives were:

Goals:

1) To identify, locate and provide health, educational, and social services for pregnant teens and teen parents not enrolled in school.

2) To improve coordination and networking of service providers involved with meeting the needs of at-risk teenagers.

Objectives:

1) To increase the percentage of pregnant teens and teen parents who re-enter the system. (The system is defined as the program of services provided cooperatively by the school district and community agencies.)

2) To increase the use of psychosocial services for pregnant and parenting teens.

3) To return 150 pregnant and parenting teens to the system over a two-year period.

4) To have 100 pregnant and parenting teens develop a career education program plan.

5) To demonstrate improved health practices of 100 pregnant teens.

6) To demonstrate an increase in services and programs for pregnant and parenting teens provided by public and non-profit public agencies.

The study also indicated the need for staff development and in-service training. TPAP was funded in January 1981 for a three-year period by the Mott Foundation to implement the needs assessment recommendations and design special services to supplement OUSD's ongoing school programs. Since the grant was for a decreasing amount each year, TPAP was encouraged to attract support from additional sources. The program has received grants from private foundations, as well as city and state agencies. Because the outside funding has been largely in the employment and training areas, the TPAP has emphasized vocational skills.

Cyesis. Oakland's TPAP has always focused more on the teenager after she delivers. This emphasis is justified by the availability of the three and a half decade old Cyesis program. First organized in 1949, the Cyesis program existed for many years as a homebound instructional program. Beginning with the 1964-65 school year, the program was organized as the Oakland Interagency Cyesis program. Its goal was to provide comprehensive services for "school-age pregnant girls," by coordinating the work of five separate agencies: OUSD, Alameda County Health, County Welfare, the YWCA, and the city Recreation Department. Two Oakland city Recreation Department Centers were used for program sites.

A two-year grant by the Rosenberg Foundation and funds from the school district financed the program in its new format for its first two school years. A grant from the Ford Foundation permitted an expanded research study. A transitional grant was secured for the third year of the program from the Oakland Economic Development Council.[22] The program maintained its interagency arrangement throughout the mid-1970s, expanding the numbers served. Enrollees

were carefully screened for their motivation and expected success and a waiting list developed. Eventually, the program expanded to the Booth Center to accomodate the increasing number of younger pregnant teens. In 1976, the program shifted its administration to the Special Education Department. Except for the city Recreation Department, which housed the program, other agency affiliations weakened. For a brief period between 1975 and 1979, one of the Cyesis centers benefited from a Regional Occupation Center (ROC) which trained students to be day care workers. Students were able to remain in the program after delivery, and child care was provided while they attended classes. The ROC day care program was slated for expansion through a special school tax appropriation referendum. However, the passage of Proposition 13 in 1978 ended that plan. The ROC program currently operates without social services, day care facilities, or follow-up coverage.

Oakland's history of services for pregnant and parenting teens shows the attempts of service providers to develop comprehensive solutions. Unfortunately, they have been unable to sustain their efforts over a protracted time period.

Factors Enabling and Hindering Service Development

Resources. Paradoxically, the greatest resource the Oakland community has in developing services to care for and prevent teenage pregnancies is its status as an underserved area. Funders have no difficulty believing their grantees face significant challenges. A positive social service culture exists in Oakland, and programs for pregnant and parenting teens are generally accepted as necessary, although they may not be at the top of everyone's priority list. In Oakland, many social service professionals are politically savvy, and they know how to lobby and compete for public and private sector grants. Said one state administrator, "Whenever there is money available at the state level, Oakland is there to apply for it."

Oakland providers have a history of coalition-building, cooperation, and developing innovative service models. The current effort by the Booth Center and the YWCA is a good example of the potential of such activity.

Many of the area service providers have been advocating better programs for many years. The administrator for the Cyesis program has worked with pregnant teens for over 15 years; the TPAP administrator has done so for nearly

a decade. The school superintendent and board are said to have been very supportive of the programs, although the schools have contributed little material assistance other than the Grant High School facilities plant.

The TPAP has established a national reputation for its emphasis on training adolescent parents to be job ready. This attention is an asset when the program makes outside contacts. So too is its diverse and well-connected advisory board. Said one worker, "We want people who have clout and who can deliver jobs."

Two final resources that providers have used in developing services for pregnant and parenting teenagers are the media and a local legislator. The TV and print media have given good coverage to issues of adolescent sexuality. An area state representative and his administrative aide have been instrumental in supporting community health services legislation that helps at-risk populations such as teenagers.

Constraints. The largest constraint to service delivery is one that service providers have little control over, poverty. The fact that about one-fifth of the city's families receive AFDC means that many of the population's social problems are fairly intractable. When the community is poor, its services too are always on the edge, and outside funders often dictate priorities.

Services to pregnant and parenting adolescents are not yet fully institutionalized and are therefore more vulnerable to service cutbacks. For example, the TPAP has no real departmental home in the Oakland school district administration. This lack of institutional linkage makes it difficult to communicate with teachers, administrators, and students. The program's physical location is also isolated from the mainstream structure. Also frustrating to the program's advocates is the fact that it is not credited with bringing funds into the district. Some administrators complain that the TPAP does not pay for itself, although by reenrolling former dropouts the program does bring additional ADA reimbursements.

Another barrier to institutionalizing the program is the current lack of interest by the academic segment of the school administration and its fear of contaminating "good" students with a "bad element." Service advocates sometimes wonder if the program is unwanted. The program serves students who some believe have already "struck out." One interviewee told us that the "academic side has yet to buy in. Those

interested in vocational education have captured the program, and the emphasis is not yet on basic skills." There are also pockets of resistance to mainstreaming the program; it is not entirely coincidental that the program does not yet have a significant presence on the regular school campuses. Said one administrator, reflecting an often expressed view that the programs create the problem, "Teenage pregnancy is a terrific problem in Oakland, and we're not making progress in attacking it... The more sex education we teach, the more get pregnant."

Also difficult to overcome are the barriers that large bureaucracies pose for would-be service innovators. In Oakland, the most perverse breakdowns in the bureaucratic structure have occurred between parallel state and local government departments. For example, state and county health officials have been arguing for four years over the appropriate data forms to use in the community-based and county health clinics. In another case, the state Department of Education practically begged the OUSD to apply for special SAPID funds (that became available near the end of fiscal 1983), but the school bureaucracy never routed the application form to the appropriate official for response. In the words of one frustrated administrator:

> I've run into so many roadblocks I don't want to even talk about them. Oakland got off on the wrong foot or on no foot, I should say. We've been trying to catch up. The state thinks we haven't been able to get programs started here. You know bureaucracies--the state has theirs, we have ours--it's very hard for us to get together to do anything--it grinds you out.

Each of these constraints is exacerbated by budget cuts and the fear of budget cuts. State and federal cuts have a disproportionate impact on cities like Oakland which rely heavily on their support. Cuts can be devastating in their broad impact. In a period of three years, East Oakland's Planned Parenthood lost 75 percent of its caseload as outreach was reduced and fees imposed. Two contracts that would have come to the TPAP were "blue penciled" by Governor Deukmejian which sent the program scrambling for replacement funds at the last minute. The chronic and frustrating search for resources makes progress towards comprehensive services for the large numbers in need seem visionary. As one worker noted, "If we don't get more money, we'll have lots of good programs for a small number (of teens), but nothing for others."

Conclusion

Oakland provides services for pregnant and parenting teens, but they are less comprehensive than those at other study sites. Providers have worked diligently within the schools, in the health community, and with many private and public sector funders to develop programs. Unfortunately, providers have yet to receive the institutional backing they need to organize a comprehensive model. The school district has not committed its own funding or administrative energy towards finding a way to mainstream some of the TPAP's special services. The Cyesis program has lost several important collaborators. The health system is comprised of clinics that provide good pre and postnatal coverage but they have lost both their special OPHP status and community-wide orientation. No agency has yet been able to replicate the work of the Family Planning and Reproductive Health Forum. No organization has been able to take a long view on the direction of social, educational or heath services because each providing agency is struggling to survive in this difficult period.

Oakland illustrates the chaotic pattern of service development resulting from reliance on temporary, special-purpose demonstration grant funding. Programs have been in constant flux because of the episodic initiation and termination of federal, state, and foundation grants.

Coordination has been hampered both by the narrow emphasis of specific programs and the defunding of the Family Planning and Reproductive Health Forum, which for a while, had served as a central coordinating body. In several other sites, this problem was alleviated to some extent by local foundation and United Way support that could be used to fill in the gaps and ease the transition between grants. No such support has been available in Oakland, however.

Like most programs, those in Oakland served a small percentage of the potentially available clientele. Consequently, outreach and follow-up services were limited or non-existent.

Oakland also offers a prime example of how the interest of a powerful political figure can produce otherwise unavailable resources. In this case, Governor Jerry Brown's "discovery" of Oakland yielded a large dividend of special though temporary grant support.

The attitudes of many of Oakland's school administrators are typical of what we found elsewhere. Many resent special programs as detracting from the academic mission, and some fear that the programs themselves are responsible for encouraging promiscuous behavior.

Perhaps the most difficult challenge is Oakland's poverty. It contributes to health, educational, and employment problems that overwhelm the limited services that are available.

IV. ELK GROVE

For the purpose of the study, Elk Grove and its neighboring jurisdictions have been considered as a single entity served by the Elk Grove Unified School District (EGUSD). This is useful for two reasons: first, the School District is the lead agency in providing services to pregnant and parenting teenagers within its catchment area; and second, the Elk Grove case illustrates the special challenges service providers and recipients must face when dealing with multiple, cross-cutting units of government.

Elk Grove Unified School District (EGUSD), located 14 miles south of Sacramento, serves the southern area of Sacramento County. Its jurisdiction extends to both suburban and rural communities including the townships of Elk Grove, Sloughouse, Florin, Franklin, and South Sacramento, a portion of Rancho Cordova, and a large unincorporated area. The district is the second largest in area in California, covering 320 square miles.

Although there is a fairly dense, heavily populated suburban area with many single and multi-family dwellings in the northern part of the district, the central, southern, and eastern sections are comprised of many small ranches, dairies, wineries, and farms.[23] In 1980, the population of Elk Grove township was 10,959, an increase of almost 200 percent from 1970. This rapid growth reflects the movement of families from urban areas to the "country." In Elk Grove township alone, the number of new housing units increased from 564 in 1975 to 2,922 in 1979.[24] The district population is now estimated as greater than 75,000, and is continuing to increase.

Recent growth in school enrollment has been especially pronounced. In 1981-82, 13,600 students were served in K-12 programs. During the 1983-84 school year, approximately 16,000 students have been served, an almost 20 percent increase over the past two years. Educational facilities include: two comprehensive senior high schools, five senior high alternative education schools, two seventh and eighth grade schools, and 16 elementary (K-6) school sites.

Occupationally, the district's population reflects both a rapidly growing professional middle class living near Sacramento and blue collar and unskilled workers scattered

through the rural areas. There are also two small air force bases with the district, and an agricultural area in the south. Approximately 75 percent of the district's population is white, and the remainder Hispanic (10 percent), black (8 percent), or Indochinese (7 percent). There is also a growing Portuguese community.[25]

Current Services for Pregnant and Parenting Teens

In the Elk Grove School District community, services for pregnant and parenting teens are centered around two programs, the Cyesis (Pregnant Minor Program) and School Age Parenting and Infant Developing Program (SAPID), located on the Daylor High School campus, situated in the northernmost part of the district.

Any pregnant or parenting student (including fathers) who has not completed high school and lives in the school district is eligible for the PMP or SAPID program. Students are referred by school personnel, physicians, nurses, social service agencies and most importantly, by other students. Although program objectives are fully complementary, the combination of these two programs on one campus is relatively unique in California. The Elk Grove programs today reflect a long-standing commitment to fully integrate prenatal and postnatal service components under one roof. The PMP and SAPID programs are located in two large classrooms in close proximity to each other. These programs have one central goal: to help the individual graduate from high school.

Besides their emphasis on preventing school drop-outs, the staff at Daylor programs have combined efforts to provide comprehensive services to pregnant and parenting teens. Between the PMP and SAPID programs there are two-full-time teachers, two directors who perform a variety of administrative and instructional tasks (one likened his involvement to "full-time case management"), one full-time social worker, and one administrative aide. There are also two part-time nursery aides. In addition, the programs make use of college and professional school interns as volunteers. One of the directors is an accredited school nurse, and the other has a teaching background.

PMP. Each student enrolled in the Pregnant Minor Program "learns the essentials of pregnancy, labor and delivery, and infant care." They spend two classroom periods per day receiving childbirth education which includes information about nutrition, labor, and delivery. These

classes take place in the morning hours during which time the students also attend regular classes with other Continuation School students. While other students within Daylor must be 16 to enroll, pregnant students will be taken at any age. The PMP offers special tutoring and individualized instruction based on the particular needs of the student. This is particularly important for the younger students. The school offers all the courses a student needs for graduation, but relatively few electives. A significant number of students from these programs graduate from Daylor. In 1983, of the 70 Daylor graduates, 22 had entered the school through the PMP or SAPID programs.

In the afternoons, when most of the students have completed their classroom instruction, more individualized services are available. Every pregnant student's blood pressure and weight are checked monthly and she has the opportunity to meet privately with the director, teacher, or social worker weekly. Crisis counseling is available as needed.

The classroom in which the PMP is based is distinctive. It actually consists of two rooms. The front room is very large with two sections, one with sofas and coffee tables where students meet for classes, films, and informal rap sessions, and the second with desks for secretarial work. A small back room serves as an examining area for the health check-ups. In both rooms, the walls are covered with photographs of pregnant students and of mothers and babies together. This creates a very special atmosphere.

The role of the social worker makes the Elk Grove program unique. The School District employs her to counsel all pregnant students in the district. Since the majority of pregnant students are enrolled at Daylor, she spends most of her time there. In addition to individual and group counseling, the social worker works closely with the Department of Social Services and local hospitals to facilitate financial aid and medical services to the pregnant and parenting students.

There are no special teen clinics or specially targeted social service programs within the Elk Grove Unified School District. However, there are informal arrangements between the PMP and other service providers both within the district and across jurisdictional lines to insure proper medical care and income support. For example, the program has close contact with those providing special teen services at Sutter Memorial Hospital in Sacramento and American River Hospital in Carmichael (both of which are some distance away). It is

now in the process of negotiating with Methodist Hospital (which is the closest hospital to Daylor) for the establishment of a teen clinic. Complete records are kept on the outside services provided to students enrolled in the PMP. Program staff believe that because of the special medical attention pregnant teens receive within the program, they are better prepared for delivery and have excellent pregnancy outcomes.

SAPID. The SAPID program is designed to provide child care for the infants and pre-schoolers of any Elk Grove School District students who have not graduated. Unlike the PMP, a number of the students using the SAPID program are not enrolled at Daylor. PMP and SAPID students and their babies are bussed from their homes to the Daylor campus. Students enrolled at other schools who use the SAPID day care facility must arrange their own transportation.

The child care facility uses three separate sections of a large classroom. The first section contains kitchen facilities to prepare meals for both babies and students. Free lunches are provided for both PMP and SAPID enrollees, and nutritional instruction also takes place here. The second section is for infants and toddlers, and the third primarily for preschoolers. The facility is licensed for 39 children ranging in age from three months to three years, and it is always filled.

Parents enrolled in the SAPID program attend classes on parenting education in which they learn about child development, nutrition, and consumer decisionmaking. They also receive group and individual counseling. Until this past year, children older than three years would automatically be referred to the Head Start Program operating in the district. However, Head Start has now excluded three year olds and the SAPID program has agreed to care for children of adolescents until age four.

Joint Services. Because the PMP and SAPID programs are so closely linked, a number of service components do not directly belong to one or the other. Students from one program intermingle with those from the other and staff include both groups in many activities. For example, family planning education and referral is conducted for both groups. Each student is referred to the family planning agency in Sacramento and may go on a yearly field trip to a local drugstore, where students locate and price contraceptives. Pregnant students are also urged to consider breastfeeding as part of the prenatal educational exercises.

The staff of both programs are also cooperating in efforts to increase male participation. One program director has had marginal success in attracting fathers to childbirth preparation classes.

The programs also offer career education and vocational preparation in various forms from year to year. In the past, some special summer funds were available through CETA for child care training. Also, since Daylor is a Continuation High School it offers classes that are "adult" or vocationally oriented within its general curriculum. Some students receive special training in public speaking through a state family planning agency grant to provide educational panel presentations about their experiences as pregnant and parenting adolescents.

Both programs offer follow-up services and the PMP is open through the summer months. (The nursery does not operate during the summer.) They make referrals for pregnant and parenting teens moving out of the district, usually by contacting a public health nurse or other local provider. They also refer to public health nurses during the summer and work with counselors at the regular schools for those teens who are going to return after delivery. Due to overcrowding at the SAPID nursery, a small satellite PMP program has been started on the campus of another alternative high school. This program has six teens enrolled in prenatal classes.

The combined program serves about 150 teenagers per year. While birth statistics are not kept by the district, the program directors estimate that some 150 of the 250-300 pregnant students drop out of school every year. In other words, they believe the programs serve between 50 and 65 percent of those pregnant students who do not have abortions. The racial composition of the program in the 1982-83 year was approximately 50 percent white, 25 percent Hispanic, 15 percent black, and the rest other.

Service Climate

The climate for maintaining and initiating services for pregnant and parenting teens in the Elk Grove district is fairly positive. The school administration has been very

supportive of these services over the years, the providers innovative, and the community at large tolerant.

The highest levels of the school administration have always supported the PMP and SAPID programs at Daylor. They have assisted in writing proposals for state funds and have eased the administrative burdens associated with combining separately funded programs. While some programs have been cut, and resources transferred, the pregnant and parenting programs have been left intact, in part because the administration understands that the programs are self-supporting.

The program directors face challenges in their efforts to establish satellite service programs on comprehensive high school campuses. As one administrator noted, "We would like to see the parenting and Cyesis (PMP) program in each high school, but there are still some stereotypes to break down. There are principals who don't like the idea of pregnant kids running around." The majority of the school board members support the extension of services if money is available. The board is proud of the programs, in part because of the significant favorable publicity they have received over the years. Because of Elk Grove's proximity to the state capital, some legislators favoring increased services have considered its programs a showpiece.

The district has also recently extended its involvement in pregnancy prevention programs. The vice president of the California Alliance Concerned with School Age Parenting (CACSAP) consulted with the district on the design of a family planning curriculum for grades five and 12 offered by the consumer economics department. This initiative did attract its share of controversy. Many members of Elk Grove's large Mormon community objected. However, the board decided to approve the proposal which includes careful screening and special training of teachers.

The schools have been able to build a broad consensus around pregnancy and parenthood programs which are not considered either "liberal" or "conservative." Some believe that the service climate is supportive because the district is so large that opposition interests have difficulty organizing. Another theory is that the government employees living in the district have a different, more positive, view of publicly funded service programs.

Because the community is so diverse, the service climate is most affected by the leadership of the Unified School

District. The administration actively supports the concept of the schools' functioning as resources for community problem solving.

Historical Development of Services

The Pregnant Minor Program was started at Daylor High School in 1970 with six students. Pregnant minor legislation had passed in 1968 at the state level as a result of various lobbying efforts linking teen pregnancy to school drop-outs.

In 1969, Daylor High School had three classes of Head Start children on campus along with its regular students. Since some of the children's parents were teenagers, the connection between day care and continued schooling was established. As the school nurse at Daylor became aware of the special needs of many of the teenagers enrolled, she solicited volunteer assistance from the American Red Cross. The current director of the SAPID program began as a volunteer. In 1970, the principal of Daylor learned about the state funds available for pregnant minor programs and started to develop a program by hiring a home economics teacher. In 1971, the Head Start program moved out of Daylor, but the PMP remained.

During 1974, SAPID legislation was passed. The current SAPID director, with district support, successfully wrote a grant for one of the original pilot programs. Within the next year, both SAPID and the PMP were operating side by side. The combination of child care and prenatal instruction was essential for building the program census. The SAPID funds for postpartum services and child care provided the drawing card that the PMP program needed. The director of the SAPID program says, "We were losing kids because we couldn't give them anything after they delivered."

In 1977-78, the district decided to assign one of its full-time social workers (there are now four) to providing services for pregnant and parenting students. Since then, the social worker, in addition to her counseling activities, has developed a large number of contacts in the health and welfare service communities and helped recruit students for the program. As the student population began to grow, funds for both programs expanded. Average daily attendance monies were supplemented by a special revenue allotment for the PMP and by a per child allotment for the SAPID day care component. Between the 1979-80 and 1980-81 school years, enrollment in the programs grew from 74 to 130. Total enroll-

ment (for both programs) peaked at 150 in 1981-82, and has remained fairly constant since. The leveling off of enrollment may reflect the fact that the SAPID component is over-subscribed and that funding has not been expanded for the past three years. The programs have now reached the capacity of the physical plant and funding levels. Future service expansion will depend on developing satellite programs on other high school campuses.

Factors Enabling and Hindering Service Development

Resources. The most important factor enabling the development of services to pregnant and parenting teens in Elk Grove is the continuity of staff responsible for the PMP and SAPID programs. Both directors have been at Daylor High for ten years or more; the social worker and PMP teacher have been there for more than five years. Two assistant superintendents with some responsibility for the program have been associated with the district for 25 years or so, and the principal of Daylor has over 15 years experience in the district. A feeling of connectedness exists among the key personnel responsible for helping this population.

Because of its long-standing interest in developing special services, the Elk Grove programs have developed a reputation for excellence that has enabled them to withstand budget cutbacks and other pressures to change program emphasis. The program directors are both statewide leaders in CACSAP and are frequently called upon for technical assistance, advice, and legislative input. State legislators, bureaucrats, and a United States Senator (S. I. Hayakawa) have visited and praised the program; administrators, service providers, and recipients have benefited from the attention.

Communication and feedback within the school system seem exceptional when compared with other communities we have studied. For example, staff development has long been supported in EGUSD. Staff persons--not just teachers, but also aides, clerical workers, bus drivers, and so on--are encouraged to increase their knowledge and skills so that they can improve their working relationships with students, parents, and other staff. The district also encourages cooperation with other education institutions, often supervising graduate students or cooperating in studies. Network and coalition-building are recognized as valuable pursuits. The district has played a key role in convening the Sacramento Community Action Network for Teens and is the

coordinating agency for the Rural Sacramento County Consortium (Title VII) project.

Another significant resource the programs have is a home that is relatively unthreatening to others in the district. As one wing in a Continuation High School of only 400 students, the PMP and SAPID programs can easily be ignored by those administrators, teachers, and parents who find the programs objectionable.

Constraints. Unlike most California districts, EGUSD experienced rapid growth. Much of that growth is uneven, concentrated in the northern sections of the district. This growth creates several problems. First, the district has a building shortage. Says one assistant superintendent, "We don't own the land that we need to own; we can't build permanent structures." Second, school budgets and per capita spending on the federal and state levels are shrinking. Because of general demographic changes in school-age populations, state budgets have been designed for decline and resources to accomodate growth are now minimal. The state revenue limit per student has remained the same over the past two years. This is especially troublesome because the district has increasing costs. A new teacher contract was signed in 1983, and the district has had to lay some teachers off to pay the salary increases.

Rising enrollments and falling revenues make it more difficult to develop satellites of the PMP and SAPID programs on other high school campuses. Schools are already overcrowded; one administrator told us, "Both high schools would open satellite programs if they had the space, but there's simply no room."

The almost exclusive reliance on state funds serves as a significant constraint on further development of services for pregnant and parenting teens. The programs have not yet attracted support from foundations for community sources. If their state funds were cut, the programs would be in severe jeopardy.

The programs are very reliant on the leadership of the directors; no prominent citizens within the district are strongly identified with the issue of adolescent pregnancy.

One final constraint on service delivery is the impact of overlapping jurisdictions. While some teenagers in the Daylor programs may have the benefit of a sensitive welfare counselor or attentive hospital nurse, others may be unable to

secure such support because they reside in another town. Such distinctions seem arbitrary and unfair. The multiplicity of jurisdictions also complicates linkages. Project staff must cultivate multiple relationships for a limited number of functions.

Conclusions

Elk Grove's PMP and SAPID programs in combination provide a wide range of services. As funds have grown and stabilized, so too have the program components. The programs have a unique atmosphere of staff cooperation and flexibility. The directors are considered experts throughout the state and their advice is solicited by other program operators and advocates.

The Elk Grove programs demonstrate the high costs of excellence and the potential vulnerability of even the best services. The state spent approximately one-third of a million dollars last year on the combined program for some 150 students and their children. If the state were to redesign or cut either the PMP or SAPID programs, Elk Grove might be in substantial difficulty.

Elk Grove also illustrates the importance of continuity of program leadership and strong administrative support. The support is sustained in part because of the excellent reputation enjoyed by the program outside the district. Within the district, its location in a separate facility keeps it out of sight of school personnel who might otherwise object.

Elk Grove is unique among the study sites in undertaking a general family planning curriculum beginning in grade five. It demonstrates that with determined leadership, such controversial programs are possible.

V. SANTA MARIA

The Santa Maria Valley, located in Santa Barbara County 170 miles north of Los Angeles in the central coast region of California, is a rapidly growing area inhabited by some 80,000 residents. Its central city, Santa Maria, is the business center for several neighboring communities including Orcutt and Guadalupe.[26] Located 12 miles from the Pacific Ocean and a similar distance from a small mountain range, the city's excellent climate and agriculture have made Santa Maria a desirable place to live. The recent growth of operations at nearby Vandenburg Air Force Base has contributed to the increased settlement of the Santa Maria Valley.

As housing has become increasingly expensive in Southern Santa Barbara County, many new families have come North to the towns in the Santa Maria Valley. Between April 1982 and July 1983 both the population and number of new dwellings in Santa Maria and Orcutt increased by about 10 percent.[27] The median age of the population is well below that of the rest of Santa Barbara County, and elementary school enrollments have been growing rapidly. In the Santa Maria Valley there are 25 elementary and junior high schools and five high schools (including private schools). Public school enrollments were nearly 13,000 at the close of the 1982-83 school year. Santa Maria had the lowest percentage of high school graduates (65.1 percent) in the county and was far below the state average (73.5 percent).[28]

The Valley's racial composition is approximately 60 percent white, 35 percent Hispanic, and 5 percent other (including 2 percent black). The Santa Maria public schools are about evenly divided along the racial lines. However, minorities have yet to gain influence in Santa Maria political life. The highest level minority officials are the city's police chief and a high school district school board member.

Occupationally, the region is affected by the air force base which employs 13,500 residents, and by farming or agri-business. In terms of income, valley residents are below the county average but are roughly comparable to state levels.[29] In 1982, there were 127 births to mothers between the ages of 12 and 18 in the Santa Maria Valley. These represented approximately 15 percent of all births in the Valley.[30]

Current Services for Pregnant and Parenting Teens

Specially targeted services for pregnant and parenting teens do exist in Santa Maria but their provision is not comprehensive. As in the other California study sites, these services are school-based in their administration, if not their physical location.

MPP. The MPP (Minor Parent Program) is located on a quiet residential street in an attractive California-style church. The program, which has been relocated twice since its inception in 1973, now has one large classroom. There are no kitchen facilities. The lone full-time staff person is a teacher who has been with the program for six years; she has directed it for the past three.

The program is funded through the Pregnant Minor revenue formula that supplements Average Daily Attendance (ADA) reimbursements. No district or other funds are now or have ever been used to provide services. A program of basic education (to allow students to keep pace with graduation requirements), child development, parenting education, prenatal and postnatal instruction is offered (as the core services the MPP can provide). The director/-teacher refers students for professional counseling, income, and health insurance. When we visited the program in October 1983, special transportation for pregnant students was provided "door to door" by the district. (See updated services below.) Follow-up services are scant. After they deliver, students are allowed to remain in the program for a maximum of one semester. No day care services exist within the program or within the school system for the mothers' infants. There is no Head Start program in Santa Maria. After leaving the MPP, students are expected to return to their former high schools, but there is no systematic follow-up.

Any student (even if enrolled in private school) within the Santa Maria Joint Unified High School District (SMJUHSD) is eligible for the Minor Parent Program as long as she is of high school age and has not graduated. The program, which besides the teacher is staffed by a one-fifth time aide, has a capacity for 30 students at any one time. Normally, about half the students come each day. Current enrollment is 24 students; 68 students were served in the 1982-83 school year. Referrals are encouraged primarily through word of mouth. Some, though not all, area physicians, teachers, and service providers are aware of and make referrals to the program.

Classes are held for a four-hour period between 11:00 A.M. and 3:00 P.M. Before lunch students pursue individual study assignments; the teacher/director acts as tutor and evaluator. After lunch the teacher/ director makes use of outside speakers and consultants who visit the program to give lectures, conduct sessions, and provide birth control information. She also leads group rap sessions in which outside participants are not included. The students have regular contact with an obstetric nurse from Marian Medical Center (one of two general hospitals in Santa Maria), representatives from Planned Parenthood, and a county social worker concerned with child abuse prevention who discusses parenting skills. The teacher/director seeks to fill in the gaps by offering information on health and nutrition, Lamaze training, improving self-esteem, and career planning. On Fridays the program meets at Delta High School (its administrative home-base), located half a mile away, to use that Continuation School's computer and audiovisual equipment for instructional and vocational training purposes.

Very few pregnant high school or junior high school students stay on their regular campuses because of the lack of special services for them there. The high school district encourages students to enroll in the MPP which is far more flexible in its attendance requirements. Junior high school age pregnant students are not eligible for the MPP, but the district provides homebound instruction for them. There were five enrolled in this program when we visited.

The Minor Parent Program does not operate during the summer months, although some students attend summer classes at Delta High. Delta also offers some prenatal education during the regular school year and its teachers are sensitive to the special needs of pregnant students.

As part of a general district-wide transportation savings plan, door-to-door service to the MPP was cut back in January 1984. Most students in the MPP no longer have their own bus schedule; they have been placed on regular bus routes with other high school students. Because many come from great distances, this is particularly burdensome for pregnant students. According to the teacher/director, students have been forced to drop out because of inadequate transportation.

Other Services. Some other area providers target services specifically to pregnant and parenting teens. The Planned Parenthood affiliate in town has an information and education grant from the state Office of Family Planning. Though it was severely cut back last year, this grant enables

the Planned Parenthood to provide education within the school system and in other social service agency programs. Some secondary teachers invite Planned Parenthood representatives into classes for lectures, films, and discussions of contraception (after receiving written permission from parents). School district policy prohibits Planned Parenthood participation in classes for grades four through nine. The district is currently considering a policy that would ban Planned Parenthood from any contact with students on campus. The local Right-To-Life Organization, which has a teen pregnancy hot line counseling operation staffed by volunteers, is currently banned from campus. In past years, some Right-To-Life representatives offended teachers and administrators by showing students abortion films that many found objectionable. The school district offers a family life education elective to its high school seniors, a course that many service advocates consider "too little, too late."

The two hospitals in Santa Maria, Marian, and Valley, have no special services for adolescents. The county Health Department serves a large teenage population in its prenatal clinic, open to MediCal-eligible women only. Its classes in preparation for labor and delivery and the provision of postnatal care are not specifically designed for teenagers, nor is there an effort to monitor or evaluate their needs. Neither hospital nor the Planned Parenthood affiliate provide abortions. However, a Santa Barbara-based physician maintains an office in Santa Maria in which he performs abortions.

Except for the worker from a state-funded child abuse prevention project who periodically visits the MPP, there are no targeted social services for pregnant and parenting adolescents. Several agencies offer individual or group counseling in which pregnancy may be one of a host of therapeutic concerns.

Service Climate

Those advocating for increased services generally face an uphill battle in Santa Maria. The service community has little access to those controlling resources and its programs have often met with a chilly reception. In general, the Santa Maria establishment is conservative and its decisionmakers are skeptical about the ability of service agencies to solve problems. The ideological leanings of many community members influence the approaches of many social service providers, school teachers, and administrators. This is particularly true with respect to services for pregnant teenagers. Teenage

pregnancy is commonly linked with very controversial sexual and moral issues, and many service providers accordingly attempt to "keep a low profile."

The city's power structure offers little support to social services. Several providers told us of the struggle to get a 5 percent set-aside of general revenue funds, about $40,000, for social services. One said, "For years and years there was no (city) money at all for social services. Then, finally, there was a big concession to give us 5 percent." The set-aside in neighboring Santa Barbara is 25 percent. The City Council is currently trying to restrict the 5 percent to support only safety and shelter services.

The MPP has stood on shaky ground in Santa Maria since its beginning. Each year the program seems to fight a new battle to survive. Advocates call the program "the forgotten stepchild," and periodically save it from termination by demonstrating that it makes money for the district by attracting additional state ADA (Average Daily Attendance) and Pregnant Minor financing. The program has withstood cuts in personnel, transportation, and other services in addition to frequent changes in administrative oversight and physical location. Program advocates have not sought to organize community support for fear that "it could cause more problems that it's worth." Supporters of the program consistently confront community members and school personnel who believe pregnant teenagers should be punished, not helped.

The district is facing difficult times. The budget has been cut over 15 percent in the past two years. Besides stressing fiscal austerity, the current administration is seeking to enforce stricter discipline (truancy problems are being attacked through police sweeps) and improve test scores by stressing basic education. As a result, special programs such as the MPP and the Continuation High School have come under increased scrutiny.

Service providers are influenced by organizational turf struggles. Because elementary and high school districts are not unified, additional layers of administration exist for those wishing to initiate services. Since the county school district operates independently, programs run by its providers often do not communicate with programs run by the local school district. Such was the case with a failed School Age Parenting and Infant Development (SAPID) program operated by Santa Barbara County schools for the Santa Maria school population.

Historical Development of Services

The Minor Parent Program (MPP) began operation in January 1973. In the 11 years since, the program has waxed and waned depending on the levels of support provided by the Santa Maria district school administration and other agencies in the Santa Maria Valley. Currently, the program faces some of its most difficult obstacles. The continued operation of the program appears in jeopardy.

The program began as a Special Education-funded project that provided a grant of $17,260 for capital, administrative, and instructional costs. Then, as now, the state grant was conditioned on the drawing power of the school to create ADA reimbursements. From its onset the program has sought to pursue several goals. First among these has been to help the pregnant high school student continue and hopefully complete her education. Other stated goals included: intervening in a crisis situation, providing medical and social services, reducing long-term welfare dependency, and preventing dysfunctional families. The program also proposed an emphasis on remedial speech and adaptive physical education.[31]

Gaining acceptance for the program was difficult. In 1968 or 1969, the founder (then the new principal of Delta) raised the question of the need for these services. He performed a needs assessment which indicated that at least 200 pregnancies occurred to school-age students within the district. Three of the five school board members in 1972-73 were physicians who recognized the health consequences of teenage pregnancy as a legitimate concern of the district, and the board approved the program's initiation.

The first semester the program was located at Delta High School. It was quickly moved off campus because of concern for the "safety" of the pregnant teens who were attending classes with other Continuation School students; it was also believed that a special nurturing environment could be established in a separate setting. This orientation governs the program to this day; pregnant students have little contact with other students except when they travel on buses together. This separation is thought to reduce the stigma attached to school attendance by pregnant students. In a community like Santa Maria, it was also important to lend legitimacy to the program by locating it in a church.

The program relocated at a Methodist Church in close proximity to Delta High. The principal of Delta remained as program administrator. The program census grew slowly, but

steadily, adding personnel and functions until it peaked in 1978-79. At this point, two teachers and two part-time aides staffed the program. More than 60 students came to the program during the academic year.

The 1979-80 year saw the program almost collapse. Daily attendance fell dramatically; often no more than five students attended school. For the entire year only 29 students went through the program. Two developments probably played a role in influencing this near collapse. The administration of the program was changed, and Santa Barbara County School District opened a SAPID program in Santa Maria in February of 1979. The two programs, MPP and SAPID, competed to the detriment of both.

The SAPID program independently faced several barriers to its establishment. It was a county program being set up by county administrators for the benefit of local district students. The county did not coordinate its efforts with the local district very carefully, as evidenced by the reluctance of the PMP to refer students to SAPID during pregnancy or after delivery. County administrators had difficulty in both finding space on a high school campus and securing classroom credit for SAPID students.

Enrollments in SAPID's day care center, licensed to serve 20 children, never grew beyond ten. MPP enrollments plummeted. Eventually SAPID failed for the stated reason that program regulations required the infant care facility to be in close proximity to the school in which the mother attends classes. Since the MPP was already isolated from a high school campus, it was very difficult to find space in close proximity. Furthermore, it was viewed by Santa Maria school administrators as another jurisdiction's problem.

The SAPID program closed in June 1981 even though the state still wished to negotiate an agreement between the two districts. The Office of Child Development obligated funds for the 1981-82 academic year so that it could reactivate the program. However, the county withdrew and the local school district never applied for the funds. There is still some hope that a SAPID program will return to Santa Maria; recent discussions on the matter have been held between county and local officials.

The MPP program began to grow again in 1980-81, reaching 55 pregnant students. The new teacher/director received assistance during the 1980-81 school year from a county Work Incentive Program (WIN) that attempted to coordinate services

for pregnant and parenting teens in Santa Barbara County. The lead agency, Youth Service Systems (YSS) subcontracted with various organizations to create linkages for serving this population. In conjunction with Santa Maria Valley Youth and Family Services and SER Jobs Incorporated, YSS worked with the MPP to rebuild its census. The WIN program, modeled after Manpower Development Research Corporation's (MDRC) Project Redirection, lost its funding in 1981.

Currently, the MPP is now operating with very limited resources. Since the change in transportation policy at the beginning of the Spring semester 1984, the program enrollment has fallen 20 percent. The teacher in charge has seen her aides cut back every year since she took over; she now has assistance one day per week. The new school superintendent is viewed by some as not supportive of the program. The school board composition has recently changed and the program's primary advocate on the board has resigned.

Factors Enabling and Hindering Service Development

Resources. The Minor Parent Program exists almost entirely through the efforts of several dedicated advocates who have resisted pressures to scale back services for several years. However, area service providers are beginning to adapt to what they perceive as an increasingly conservative climate. Considering the barriers to service provision in Santa Maria, it is impressive that any special services for pregnant teens exist at all. Although a significant need for comprehensive services exists, ideological, social, and economic obstacles constrain their development. One factor that may contribute to political conservatism is the lack of leadership exercised by the large Hispanic community.

Constraints. Services to pregnant teenagers have been ensnarled in controversy. The community has difficulty admitting that teenage sexuality is a legitimate social concern that should be discussed publicly. Some groups have criticized what they consider the influence of liberal groups like the Planned Parenthood in school classes. Organized protesters tried to prevent Sol Gordon, a lecturer from Syracuse University, from making a presentation a few years ago. But, more significantly, many community members prefer to ignore problems like teen pregnancy. One respondent told us:

> "The community just doesn't want to talk about it (sex). Their anger comes out... Sex is for the privacy of one's own home... The problem always was, in setting this program up in the first place, that sex is nasty, dirty, a bad thing that people shouldn't do."

Another said:

> "When people start to talk about this, it's like opening a blast furnace--whomp--the fear it raises."

The financial barriers to service provision are formidable. The school district has trimmed its budget dramatically in the past two years; many teachers and counselors have been laid off. This has occurred during a time when school enrollments have been rising. Last year, 11 counselors were replaced by aid "technicians" at significantly lower salaries. The district has stripped the MPP of its independent operating funds, arguing that reimbursements for the programs are from the general operating fund. While this is technically true, regulations at the state level (which have never been implemented or monitored) would presumably not allow the district to pay off other accounts with MPP-generated revenues.

The absence of a unified school district is an additional constraint on service development. The state still hopes to fund a Santa Maria SAPID program, which unquestionably could draw a large number of program enrollees were the two districts, Santa Barbara and Santa Maria, able to coordinate their efforts. Yet the incentives for such cooperation are not great and the obstacles are formidable.

The tension between school district administrators reflects a larger struggle between Southern and Northern Santa Barbara County. The city of Santa Barbara, located in the Southern part of the County, is considered a much more attractive place to live than Santa Maria in the North. The availability of and advocacy for services has been greater in the South. For example, model PMP and SAPID programs exist side by side in Santa Barbara. Organizations have their main offices and spend their most money in the South, and many service providers in the North prefer to reside in the more comfortable setting in the South.

Conclusions

The experience of Santa Maria illustrates the limitations of program development in an unsupportive local environment. Services for pregnant and parenting adolescents are minimal. While some effort is made through the MPP to keep students in school, linkages with social and health services are tenuous. In short, the services that do exist are limited, fragmented, and are now reaching a lower percentage of adolescents in need of help.

Unfortunately, the prognosis for an improved service outlook is not bright. While a small dedicated group of supporters has been able to sustain some type of school-based services for the past 11 years, their time may be running out. They have avoided publicizing the program for fear of negative community reaction, and the program has been based off-campus. Because of the lack of outreach and the cuts in transportation services, the program census is down significantly.

NOTES

1. Statistical Abstract of the United States, p. 427.

2. Michael Kirst. The new political conflict in state education finance. Taxing and Spending, 1980, 3, 17.

3. Ibid, p. 18.

4. California Health and Welfare Agency, Office of Health Statistics.

5. California Department of Education, Office for Child Development. In-service for Pregnant Minor Program, 2/81.

6. California Education Code, Regulations Implementing Provisions of Chapter 1504 of the Statutes of 1974 (SB 1860).

7. California State Department of Education, School Age Parenting and Infant Development Program: Regulations Implementing Provisions of Chapter 1504 of the Statutes of 1974 (SB 1860). Sacramento, CA: Office of Child Development, 1980.

8. California Department of Education. Infant care and development for parents of high school age, 1975-1977. Sacramento, CA: Office of Child Development, 1978.

9. California Health and Welfare Agency. Governor Deukmejian's special address on public assistance. Sacramento, CA, January 1983.

10. California Alliance Concerned with School Age Parenting. Fact Sheet. Sacramento, CA, 1983.

11. Boston Globe, April 1984, 25.

12. Interagency coordination: In concept and practice. Unpublished paper, Fresno, CA, 1983, p. 4.

13. Fresno Community Council. Task Force on Teenage Pregnancy Progress Report. Fresno, CA: FCC, 1980.

14. Ann Shine. Final Report: Council on Child Abuse Prevention Parenting Task Force. December 9, 1980. Fresno, CA: Fresno Interagency Committee.

15. Anita McCready. Pace Observations 1982-83. Fresno, CA: Fresno United School District, June 1983.

16. Department of Social Services. Policy and Procedure Guide. Fresno, CA: DSS, October 1982.

17. California school districts face cutback. The Wall Street Journal, July 13, 1983.

18. Alameda County Department of Health, Office of Health Statistics.

19. Family Planning and Reproductive Health Forum. OPHP Report, Unpublished manuscript, Oakland, CA, 1981, p. 3.

20. Ibid.

21. Donald Binsacca et al. Report of prenatal women and infants enrolled in Oakland Perinatal Health Project and Obstetrical Access Program. Oakland, CA: Alameda County Health Care Services Agency, December 1982.

22. Cyesis program document written by John J. Carusone, Program Coordinator for the Oakland Unified School District, 1967.

23. Ronda Simpson. Responsible family planning: Bilingual multicultural approach. Proposal to California Office of Family Planning, Elk Grove, CA: Elk Grove Unified School District, 1983, p. 1.

24. Ibid, p. 2.

25. Ibid.

26. Santa Maria - 44,308; Orcutt - 26,087; Guadalupe - 9,083; population figures cited by Chamber of Commerce, 8/83.

27. Ibid.

28. U.S. Census 1980.

29. U.S. Census 1980.

30. University of California, Santa Barbara, Data File, Community and Organization Research Institute. Births were Santa Maria - 113, Guadalupe - 14, Orcutt - 0.

31. Santa Maria Joint Unified High School District. The minor parent... Whose dilemma? Proposal for Minor Parent Program, 1972.

Chapter 4. Massachusetts

I. STATE POLICIES AND PROGRAMS

Massachusetts has a vibrant economy. Its unemployment rate for the past two years has been among the lowest of the industrial states, dropping below 5 percent in May 1984. However, property taxes have been particularly high, comprising about 45 percent of the revenues collected by state and local government. In 1980, Massachusetts voters approved Proposition 2 1/2 which capped property taxes at 2 1/2 percent of assessed value. The measure placed many cities and towns in serious financial difficulty and threatened basic services, but the state diminished the impact of cutbacks somewhat by increasing local aid contributions.

The property tax revolt did not diminish the role of Massachusetts as a developer of innovative programs for populations in need. Massachusetts has a reputation for broad coverage that often supplements the eligibility standards established by the federal government. For example, although Massachusetts ranks 43rd in the percentage of its population below the poverty line, it ranks 5th in the percentage receiving public assistance, and eighth in its basic AFDC grant per month.[1] This commitment is also reflected in the recent expenditures for programs aiding pregnant and parenting teenagers. Massachusetts is presently approaching the problem vigorously.

The commitment of state government to populations in need, such as pregnant and parenting teenagers, is both supported and limited by the strong influence of the Roman Catholic Church. More than half of all Massachusetts citizens belong to the Church. While the Church has generally supported generous treatment of those without adequate food, shelter, health care, and education, it has sought to limit public intervention on reproduction issues.

State Programs for Pregnant and Parenting Teenagers

Massachusetts funds services for pregnant and parenting teenagers through the Departments of Public Health (DPH) and Social Services (DSS). Each of these departments has also designed program models, provided technical assistance

to local providers, evaluated programs, encouraged coalition-building, and lobbied the legislature for increased services for this population. Despite their efforts to develop systems which would enable comprehensive services to be developed at the local level, these departments have not been successful in overcoming certain organizational and interagency barriers to achieving their goals.

Department of Public Health

State interest in special services for pregnant and parenting teenagers can be traced to the early 1970s and the Department of Public Health's Division of Family Health Services (FHS). During that time, the Division used general "adolescent health" program dollars from the state budget to help fund alternative school-based programs in Springfield (the PAGE program) and Worcester (the SAM program). The DPH funding went towards the infant care components of these programs rather than focusing on family planning or primary care for the mother. This emphasis reflected the organization of DPH and the manner in which program dollars flowed from the federal government to local agencies. In Massachusetts, Family Planning dollars are not filtered through state or county administrative offices; they flow directly to local providers through a regional contracting process.

Until fiscal 1982, 14 separate Family Planning (Title X) contracts were consolidated into five regional contracts. Counties in Massachusetts serve mainly as judicial boundaries with little administrative power and few functions; instead, regions have been designated to perform decentralized program administration. The state DPH never developed an Office of Family Planning; it designated a Director of Family Planning (half-time until 1982 and full-time since then) within the Division of Family Health Services to handle liaison activities and legislative affairs.

The DPH strategy in developing family planning services was to avoid conflict with the legislature. Instead of lobbying the legislature for controversial increases in family planning outlays, DPH supported its local providers in their attempts to attract federal funding by providing technical assistance and linking agencies in service delivery coalitions. While this strategy was largely successful in keeping family planning matters off of the state legislative agenda for much of the 1970s, it created problems for the Department with the federal government.

In 1979, the state DPH was cited by the federal Department of Health and Human Services for being out of compliance with Title V Maternal and Child Health regulations because of its lack of attention to family planning. As a result of the DHHS report, DPH joined the Department of Public Welfare in lobbying the legislature for additional family planning funds to be administered by the state. The legislature appropriated over $1 million for specially targeted adolescent family planning projects in fiscal 1980 that were to supplement Title XX funds administered by the Department of Public Welfare. However, when the state reorganized its DPW and created a separate Department of Social Services that same year, these funds were placed in the new agency's regional offices budget. They were no longer earmarked solely for adolescent family planning programs. (See DSS description below.)

Throughout the late 1970s and early 1980s, the Family Health Services Division of DPH provided support for what it called "comprehensive adolescent health programs" and "services for pregnant and parenting adolescents." The goal of the comprehensive program was to reach adolescents "at risk" because of physical and psycho-social conditions such as alcohol and drug abuse, venereal disease, suicide and early pregnancy. Using an RFP process, six programs for comprehensive adolescent health care and two Visiting Nurse Association programs for pregnant and parenting teenagers were funded in the five-year period between fiscal years 1978 and 1982.

Meanwhile, the Office of Adolescent Pregnancy Programs had funded three comprehensive pregnant and parenting programs in Boston (St. Margaret's), Worcester (ACCESS), and Pittsfield (CANBE), under Title VI of Public Law 94-626. In 1983, DPH received $600,000 when the Omnibus Budget Reconciliation Act consolidated Title VI funds into the Maternal and Child Health Block Grant. DPH viewed 1983 as a transition period and assured the continuity of the three Title VI programs for that year. The extra funds from the federal Office increased the adolescent health budget from $440,000 in 1982 to over $1 million in 1983. In fiscal 1984, appropriations grew to over $1.2 million for adolescent health. (See Table 4-1.) At that time the Department again used the RFP process to distribute funds for adolescent pregnancy programs.

Both the general adolescent health programs and the programs specifically for teenage parents have focused on primary prevention through education and outreach activities.

Comprehensive health care is said to be available to adolescents including diagnosis and treatment of pregnancy, sexually transmitted diseases, depression and substance abuse. Every program attempts to address the special needs of pregnant teenagers and some extend services into the postpartum period. These programs attempt to provide a continuum of care for the mother and her baby monitoring their health and psychosocial needs for up to two years after delivery. All programs provide case management which coordinates health, educational, and social services and follows individual clients throughout the service delivery system. The Division has been most receptive to funding programs that are part of local coalitions and that can demonstrate effective service coordination.

Table 4-1

Adolescent Health Contracts FY '78-'84 - Massachusetts

Year	Amount
FY '78-'80	$ 437,080
FY '81	439,972
FY '82	440,501
*FY '83	1,035,542
FY '84	1,240,896

*Approximately $600,000 added to budget from MCH block grant adolescent pregnancy component.

To improve its evaluation and assessment capabilities, the Division requires the use of a standardized data collection procedure by its adolescent pregnancy program grantees. The three former OAPP grantees agreed to continue their data collection (mandated by federal program contracts) in a standardized form that enables cross-program comparisons. Massachusetts is one of the first states to attempt to monitor different adolescent pregnancy programs using a standard data system.

Department of Social Services

Since the early 1970s, the Department of Public Welfare (DPW), under Title XX, had funded counseling programs to address the special needs of adolescent parents. These contracts provided support to organizations such as the Crittenton Society and Catholic Charities to counsel teenagers and their families. The contracts were routinely rolled over each year and little attention was paid by DPW to the broader social service needs of the population. Other DPW contracts that affected young parents were usually crisis oriented and attempted to address child abuse and suicide with short-time interventions.

DSS inherited these programs when it was established in 1980, but it began immediately to shift away from crisis intervention towards prevention. It concentrated on greater advocacy and outreach to support family life and sought to gain the cooperation of community institutions such as the schools. Since DSS was committed to decentralized decision-making by regional offices, the distribution of funds for adolescent services was largely determined at that level. The legislature's fiscal year 1980 appropriation to supplement Title XX Family Planning for adolescents went from central office control in DPW to regional office control in DSS when the Departments were reorganized in 1980. Some public health professionals believe that this shift in administration resulted in the diffusion of funds which could have been specifically earmarked for adolescent pregnancy prevention. The DSS regions now use these Title XX dollars to fund general family planning services; the Department estimates that 30 percent of their users are teenagers. Funding for this program was $1.2 million in fiscal year 1983.

During its brief history as an executive level agency, the Department of Social Services has emphasized special services for young parents. The first DSS commissioner, Mary Jane England, became interested in teen pregnancy as a private clinician during the early 1970s when she provided expert testimony in the court case of a Boston area teenager who had been expelled from school because of her pregnancy (the Ordway case, 1971). Ten years later, England successfully lobbied the legislature for the passage of a "Young Parent's Initiative" (YPI). Under her leadership, the regions began to take a greater interest in comprehensive services to

pregnant and parenting teenagers and with the passage of YPI in fiscal year 1982, ten new programs were funded. Increasingly, these programs broadened their scope, focusing on outreach, school-based as well as community-based models, group activities, information and referral, and education for prevention. By 1983, about 1,100 adolescent parents were receiving services in these programs statewide; for fiscal year 1984, the YPI was funded at the $1 million level by the state legislature.

When the Young Parent's Initiative was passed by the legislature in late 1982, an open RFP process took place. The RFP included three acceptable service models: school-based services, community-based services, and family resource services. The Department defined these categories as follows:

> School-based Services. Programs within public high schools that provide comprehensive and coordinated support, counseling and advocacy for pregnant and parenting adolescents, as well as training for school personnel regarding adolescent pregnancy and parenting.
>
> Community-based Services. Programs that provide comprehensive services to pregnant and parenting adolescents living at home, that prepare them for childbearing and provide the necessary support for completing their education and/or securing employment.
>
> Family Resource Services. Programs that develop alternative family living arrangements for pregnant and parenting adolescents and help them to return to their biological families, when appropriate, or assist them in the transition toward independent living.[2]

The central office of DSS, over the objections of many at the regional level, took major responsibility for the review process. Programs with a history of working with teenage parents received higher priority scores because of the need to minimize start-up time and demonstrate success prior to reauthorization by the legislature. Ten programs were selected: three school-based; eight community-based, and two family resource.

Each of the ten funded programs (all of which were refunded for fiscal year 1984) could choose to serve teenage parents in any or all of the service models set up by DSS. The goals of each model were similar; they all focused on reaching pregnant and parenting teenagers in convenient

settings: at home, in school, and at community health facilities and recreational centers. In this way, the Department reasoned, young people ordinarily reluctant to seek out services might find them in places to which they had easy access. Programs were also directed toward serving the entire family unit (including the baby's father).

The goals of the program were stated in easily quantifiable terms: to remain in or return to school, to avoid subsequent unplanned pregnancies, to locate employment, and to become self-sufficient.[7] These goals were related to the desire of the Department and the legislature to do something about the public perception that Massachusetts welfare caseloads were too large. The program models and goals were also designed to avoid controversial issues: publicly funded family planning and day care services. Service advocates learned that the potential for cutting welfare expenditures by reducing long-term dependency and for preventing child abuse were important selling points with the legislature.

An examination of YPI's progress uncovers three problems. The first was the difficulty in implementing comparative program evaluation beyond the first year of operation. Joint evaluation of the DPH and DSS projects was proposed, but the two agencies were unable to agree on the specific forms, procedures, and timetables. The second problem was the scarcity of school-based programs among applicants. Finally, the current DSS Commissioner (Matava) may not have the same commitment as former Commissioner England (who left her post in 1983) to expanding the programs. Amidst continuing controversy about child abuse in Massachusetts, DSS has recently emphasized child abuse prevention and has moved away from service delivery in other areas, including adolescent pregnancy and parenthood.

Department of Education

The state Department of Education (DOE) does little to increase the involvement of Massachusetts public schools with pregnant and parenting teenagers. DOE has little discretionary money for programs at its disposal. The Department manages specific federal and state program mandates such as special, bilingual, and vocational education. Policy and curricular decisions in other areas are left to the local systems.

The Department has taken a "go slow" attitude on sex and family life education. The only agency policy governing

sex education is a requirement that a locality introducing a new curriculum set up a committee of citizens to meet every other month with the local school board. In Massachusetts, although health education is mandated, a family life or sex education component is not. One study respondent told us, "Ironically, the best sex education is being taught in Catholic schools. At least they're not confused over what values to imbue."[4]

The DOE has indicated that teenage pregnancy is not a priority because of the interest of other state agencies. One administrator told us, "Agency goals should not overlap too much." This orientation inhibits interagency collaboration.

Special State Policies - Department of Public Welfare

The state Department of Public Welfare (DPW) determines eligibility for several social welfare programs that affect pregnant and parenting teenagers, including Aid to Families with Dependent Children (AFDC), Medicaid and Project Good Health (the EPSDT program). The status of unmarried adolescent parents and of unemancipated minors in the state, as well as considerable controversy over the public funding of Medicaid abortions, complicate the delivery of these services to needy recipients.

With regard to abortion services, the status of pregnant minors has changed several times in the past decade. In 1974, the legislature passed a bill over Governor Sargent's veto which stated that all unemancipated minors (a woman under age 18 can only be legally "emancipated" in Massachusetts if she is married) must seek parental consent for abortion. If consent was refused, the pregnant minor could then seek judicial intervention in a Superior Court. The constitutionality of the statute was immediately challenged. After a long series of court tests, the bill was ruled unconstitutional by the U.S. Supreme Court in 1979 (Belotti vs. Baird).

The following year (1980) the state legislature passed a new law which placed the responsibility on the physician performing the abortion. The law stated that no physician could perform an abortion on an unmarried minor without the consent of both of her parents or the consent of a Superior Court Judge. This law has been subject to a constitutional challenge in the case Planned Parenthood vs. Bellotti (pending), but unlike the earlier law, it has been implemented. The result has been a decrease in abortions for

minors in Massachusetts, matched by a commensurate increase in abortions to Massachusetts minors in adjacent states.[5]

The 1980 legislation does not apply to family planning services for minors. Chapter 112, Section 12F of the Massachusetts General Laws, states that any minor may give consent to her medical care if she is the parent of a child or is pregnant or believes herself to be pregnant. (This section proscribes minor consent for abortion or sterilization services.)

In 1982, federal regulations were revised to give states the option of providing Medicaid either upon medical verification of pregnancy or in the third trimester. Massachusetts chose to keep its policy of providing coverage upon verification. (Medicaid recipients are also automatically eligible for services through Project Good Health, the state's Early and Periodic Screening, Diagnostic and Treatment Program). The same eligibility standards do not exist for AFDC which, before 1982, was available upon verification, but is now available only in the third trimester.

Eligibility requirements for both Medicaid and AFDC are also based on the relationship between unemancipated minors and their parents. If the pregnant minor is living at home, she may not (be eligible to) form an independent household unit for eligibility purposes. AFDC and Medicaid eligibility is determined by a means test which considers the available income of the pregnant minor's mother and father, and may be conditioned on the amount of aid the family is already receiving. When determining the AFDC or Medicaid eligibility of the newborn baby, only the mother's income (not the grandparents') is considered.

Interagency Cooperation

Massachusetts has a history of forming interagency committees to link strategies and program approaches. The current Governor has formed well over 100 of these committees. As yet, however, little progress has been made on interagency approaches to serving pregnant and parenting teenagers.

Both DPH and DSS have agreed to participate on the task forces organized by the statewide Massachusetts Coalition for Pregnant and Parenting Teens and the Boston-based Alliance for Young Families. Each has expressed its desire to

support the development of local coalitions to facilitate comprehensive services. Yet, for a variety of reasons, some structural, others more idiosyncratic, the two agencies in the words of one expert, "...are attempting to serve the same population but their efforts are almost totally separate."

Past efforts to build interagency communication and joint planning have collapsed over defining the appropriate role for central and regional actors. In 1980, the Director of Family Planning for DPH attempted to organize a broad interagency task force that included representatives from state agencies, the Governor's office, and local providers. The primary goal was to determine whether or not a statewide OAPP proposal should be developed. There were battles over which agency was responsible for taking the lead, whether state Special Education dollars could appropriately be spent on this population, what the population needed, how an interagency initiative could be financed, and the need for parental consent. Ultimately, the group disbanded because of disagreement on one key issue: whether a state program should exist or whether local communities should develop their own services. The highly decentralized DOE, for example, did not have the same organizational goals as DPH. When DSS was reorganized shortly thereafter, many of those serving on the Task Force were out of jobs or reassigned. The emphasis on local control was strengthened.

Although the failure of a centralized effort had its costs, leadership in the state bureaucracy remained involved in pushing the concerns of pregnant and parenting teens. They shifted their emphasis to grassroots advocacy. For instance, DPH's director of Family Planning convened a series of practitioner workshops and conferences designed to provide technical assistance to providers and to encourage community coalition-building. Ironically, while the state agencies were having difficulty agreeing on how to combine efforts, the DPH and newly organized DSS began to encourage interdisciplinary cooperation at the local level. The emphasis on local advocacy was solidified by the development of a statewide coalition. The Massachusetts Coalition on Pregnant and Parenting Teens (MCCPT), formed in late 1981, included local providers and administrators, as well as state policymakers and experts.

State Coalition/Advocacy Groups for Pregnant and Parenting Teens

According to the MCCPT's first newsletter published in Spring 1982, the goals of the Coalition are: 1) to promote

public awareness of the issues pertaining to teen pregnancy and parenthood; 2) to advocate on behalf of pregnant teens and adolescent parents; and 3) to promote resource and information sharing among agencies serving this population.[6] The Coalition consists of approximately 50 members, few of whom are men. The organization is funded solely by membership dues and the in-kind contributions of the participants. Despite the lack of advocacy experience among its members, the Coalition has had some notable successes. One DSS official credited the Coalition's lobbying with rescuing the Young Parent's Initiative after it had been cut from the Governor's budget in 1982. The Coalition has also organized several conferences across the state.

The Alliance for Young Families, a non-profit consortium of agencies serving pregnant and parenting adolescents in the Boston area, received funds from the Rockefeller Family Fund and the Ford Foundation in 1983. Those funds, in part, were committed to convene a statewide task force on school-age parents that would: 1) identify state policy barriers to comprehensive services which support school completion among pregnant and parenting adolescents; and 2) develop strategies to eliminate those barriers. The task force consists of some 30 representatives of public and private agencies throughout Massachusetts, including the MCCPT, DPH, DSS, and other executive-level departments, local and state educational authorities, provider agencies, national experts, and legislative staff persons.

The task force has developed a series of policy papers on the specific educational, vocational/employment, day care, and basic service needs of teen parents. The group has written testimony for the Joint Legislative Committee on Education and lobbied key policymakers and legislative staff. The task force is currently developing a "state action plan" which will consist of several policy recommendations and advocacy strategies. The success of the task force will ultimately depend on how seriously the legislature and executive-level administrators consider the work of an outside group (the Alliance) which has convened middle-level bureaucrats to perform planning functions.

Current Legislation

A new legislative initiative being prepared by the Senate Ways and Means Committee would seek to reduce infant mortality rates by: 1) requiring a statewide analysis of infant mortality and low birthweight by census tract;

2) committing additional Maternal and Infant Care program funds to five areas of Massachusetts where uninsured women not eligible for Medicaid are having trouble getting access to prenatal care (Cape Cod, Lowell, Taunton, Holyoke, and Lynn); 3) more aggressive outreach programs to identify women at high risk; 4) a $3.7 million supplement to the federal Special Supplementary Food Program for Women, Infants, and Children (WIC); and 5) a continuation of efforts begun in fiscal year 1984 to educate pregnant women about the risk[7] of smoking and alcohol abuse for their unborn children.

The Senate Ways and Means Committee is also examining ways to address the continuing shortage of obstetricians participating in the Medicaid program. Although half of the practicing physicians in Massachusetts participate, only 29 percent of obstetricians-gynecologists accept Medicaid payments. Even this figure masks a more severe problem of access to OB-GYN services in some areas of the state. For example, in the Worcester region, the ratio of participating obstetricians to pregnant women is only one to 100 according to a Ways and Means report. To address this program, the Committee is drafting a regulation that recommends that the State Rate Setting Commission establish a single Medicaid fee for all prenatal visits and delivery. This "global fee" would "emphasize the need for continuous access to prenatal care and would reduce billing paperwork for OB-GYN doctors."[8] Such a development would probably improve the accessibility of prenatal care for all needy pregnant women, including adolescents.

Conclusions

State support and funding for comprehensive services for pregnant and parenting teenagers exists in Massachusetts, but executive-level commitment to these services has been limited. Little, if any, Department of Education leadership has been exercised; the commitment of Department of Social Services which has the only specially authorized state funds for young parents may be changing under a new commissioner; and the Department of Public Health's contribution comes largely from federal funding.

With $1 million of DSS funds committed to the YPI, over $1.4 million of DPH funds targeted to adolescent health, and many regional DSS contracts awarded for agencies serving teenage parents, Massachusetts has the ability to make a sizeable impact on its relatively small pregnant and parenting

adolescent population. However, the current emphases of the two lead agencies reduce this potential.

II. WORCESTER

The city of Worcester, located 40 miles west of Boston in central Massachusetts, has long been considered an important manufacturing and commercial hub for New England. Despite some decline in its population over the past decade, Worcester, with a 1980 population of 161,799, is the third largest city in New England. In fact, with a 50 mile radius of the city--the census bureau's "standard location area"--there is a total population of more than 6 million persons.[9]

Worcester grew up as an industrial town with great product diversification, producing steel, machine tools, firearms, wire abrasives, shoes, cabinets, textiles, looms, steam turbines, and many other durable products. The city and its surrounding area were home to some of the nation's most prominent inventors including: Ethan Allen (wire and firearms products), Elias Howe (the sewing machine), Eli Whitney (the cotton gin),[10] and Russell Hawes (envelope production).

Today, after losing several manufacturing industries, the city is attempting to revitalize its economic base. The Centrum, a 13,000 seat civic center, opened in the fall of 1982. Since 1978, over $50 million has been invested or committed to major downtown developments including new office buildings, shopping centers, and parking facilities. A 75 acre biomedical research park is currently being planned in hopes of attracting high technology companies.

As industry has made Worcester an important regional city, so too has its tradition of academic excellence, especially in higher education. Eight four-year colleges and four junior colleges are located in the area. A state university medical school has opened in the past decade, and it includes a teaching hospital that is making a great impact on the city's health agency structure.

The city's population is somewhat less well off than others in Massachusetts primarily because of its reliance on declining manufacturing trades. About 30 percent of the area's workforce is employed in manufacturing, which may explain the city's higher rates of unemployment relative to the state average.

Current Services to Pregnant and Parenting Teens

Two programs satisfy most of our requirements for comprehensiveness, the School Age Mothers (SAM) and ACCESS. While ACCESS serves larger numbers than SAM and performs more systematic client follow-up, the programs deliver vital, complementary services. Because they are fairly well linked, Worcester pregnant and parenting teenagers have far better services than are available in most cities.

SAM

The SAM program represents a partnership between the Worcester School Department and the Worcester Children's Friend Society. It also receives city funds. The School Department provides four part-time teachers, a bilingual aide, educational counseling, school materials, and two meals per day. Children's Friend provides the full-time director (a social worker), a full-time nurse who offers health education, infant day care, and parenting instruction. Two child development specialists and two part-time aides operate a licensed day care center for ten infants, aged four weeks to six months. These services are offered at the Worcester Girls Club. No effort has been made to provide special services to pregnant teenagers on regular junior and high school campuses in Worcester.

Any Worcester woman who is pregnant, age 21 or under, and enrolled in high school is eligible for SAM. In the past, cities outside of Worcester also sent students, but this has stopped with Proposition 2 1/2 cuts. The program has a capacity of 40 students and now, with turnover, averages between 70 and 80 per year. The racial composition is approximately 30 percent Hispanic, 10 percent black, and 60 percent white. Students are referred by community providers, former enrollees, and school counselors. The program meets daily between 8:30 A.M. and 1:00 P.M.; no summer program is offered. Until 1983-84, funding was provided by the School Department and Children's Friend, which in turn received United Way, City of Worcester, and state funds. In the past, the School Department was able to contribute Chapter 766 Special Education reimbursements, but can no longer do so under state law. The School Department's contribution is now limited to the provision of staff, materials, bus passes, and food. A state-local Department of Social Services matching program and the Children's Friend operating budget make up the balance of support.

Students enrolled in SAM are offered the same curriculum as in the Worcester School Department. Each student receives individualized instruction to help her keep pace with her classmates at her home school. Depending upon the number of students taking similar subjects, some classes may be taught on a group basis. In addition to basic instruction, home economics, sewing and physical education are also available. The Girls Club swimming pool is used on a limited basis. While in SAM, each student remains enrolled in her home school, and attendance records and grades are maintained there. Students must return to their regular schools (at which point they become ineligible for day care at SAM) the semester after they deliver. The day care center is limited to ten infants, and SAM enrollees with children must rotate their arrangements.

Students have the opportunity to participate in individual and group counseling sessions. Two types of groups are offered. One focuses on practical issues such as budgeting and exploration of community resources, and the other is a peer support group.

Each program participant receives her prenatal and postpartum care from a health clinic or private physician; students are often referred to ACCESS for these services. The SAM health component includes health counseling and education. Each student is seen regularly by the nurse who also communicates with the students' health care provider. The nurse teaches classes in childbirth education, child development, and general health. Family planning education is also emphasized in an attempt to reduce future unwanted pregnancies. Aside from the two reunions held yearly, the program makes no systematic effort to follow up on participants' progress.

ACCESS

The ACCESS program closely monitors the progress of its participants through central intake and follow-up procedures performed by Family Planning Services of Central Massachusetts (FPSCM). This medically-based program operates out of three main service delivery sites and FPSCM. It has been in operation since 1980 when it was funded as one of OAPP's four original demonstration grants under Title VI.

The central program staff includes a coordinator, an assistant coordinator, a secretary/receptionist, and a small portion of the executive director's time at the FPSCM site.

There are six social workers, one prenatal and one postnatal worker at each medical site. Each medical site also provides the following staff through an agreement with ACCESS: an administrator, physician, nurse practitioner, support nurse, nutritionist, clerk, and a receptionist. Participants are eligible for ACCESS services if they are pregnant or parenting and residents of Worcester County. The program targets teenagers 17 years or younger as its primary client population, but serves anyone in need under age 21. The program also serves the children, extended family members, partners and boyfriends of pregnant and parenting teens. In fiscal year 1982, the program served 378 "unduplicated pregnant and parenting teen clients."[11] This included 218 cases of comprehensive prenatal services, the most extensive coverage that clients receive. In 1983, the number of clients grew to approximately 400, but those receiving comprehensive prenatal coverage fell to about 150.

Prenatal and postpartum adolescent pregnancy clinics operate at Hahnemann Hospital, Memorial Hospital, and Family Health and Social Service Center. All clinics meet weekly, perform free pregnancy tests, and follow clients two years after delivery. Each teen is assigned an advocate who assists her throughout her pregnancy and following delivery. Postpartum home visits occur at three weeks, three months, and intermittently thereafter to check on the progress of mother and child. Each site also provides the following: maternity counseling and referral; family planning services; nutrition information, education, and counseling; family life education; client advocacy and referral to educational and vocational services; adoption counseling and referral; child care counseling and referral; consumer education and homemaking; individual and group counseling for extended family members and male partners; and transportation. (A local foundation donated a van that is used extensively.) In addition to pregnant and parenting teenagers, the ACCESS program served the following caseload in 1982: 308 infants of the adolescent mother clients, 100 partners, 1601 non-pregnant adolescents through outreach/education, 120 parents of pregnant or parenting teen clients, and 557 parents of non-pregnant adolescents.[12]

The close relationship between the pregnant teenager and her social worker is said to be a key component. Follow-up includes an emphasis on medical care for the mother and child, and identification of situations that require further intervention.

ACCESS is community-oriented; it draws support from over 60 community agencies that are part of its referral network. The three medical institutions are responsible for staffing their own sites. Program administration had been provided by the original three-year OAPP grant (fiscal years 1980, 1981, and 1982). It was extended by the Department of Public Health's fiscal year 1983 MCH block grant funds. That support was withdrawn in 1984 at which time FPSCM drew upon other grants to maintain the ACCESS administration. The current operating budget of $165,000 supports the social workers; most of these funds come from a state DPH grant for adolescent health, and the rest from private sources.

Other Programs

Two other special programs for pregnant and parenting teenagers have operated in Worcester over the past few years with some success; one maternity program has operated for several decades. The Teen Parent Program (TPP) is operated by the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC). Conceived by the second community group studying teen pregnancy (the SSCW group), the TPP operates as a very structured parenting education program for teenage parents. The MSPCC, whose organizational credo is "Kids. You Can't Beat Them," funds a program for two groups which each meet twice per week. It currently focuses on short-term intervention limiting its services to an eight-week period of contact. Nearly all of the program participants, aged 21 or under, are high school drop-outs. Two part-time child development specialists and one aide staff the program. Services include transportation, professional supervision of child care, meal preparation, family life and child development education, group rap sessions, individual counseling through home visits, referrals to other community providers, and transportation.

A similar protective emphasis is embodied in the Children's Friend Protective Outreach Program first organized in 1979. It was designed to help young mothers cope with the demands of parenthood. The program is coordinated by a CF social worker and includes an outreach worker and a parent aide. The outreach worker refers clients to community services, staffs recreational and discussion groups, and helps with day care arrangements. The parent aide assists new mothers with child care and household management after their return from the hospital. The program is funded by the Department of Social Services.

The maternity home at Catholic Charities (CC) Marillac Manor is Worcester's oldest program for teenage mothers. The home, which is located directly across the street from both St. Vincent's Hospital and the SAM program, has a capacity of 11 teenagers. CC runs a clinic at Marillac which is staffed by a nurse and provides individual, group, and family counseling for pregnant teenagers. Those who participate in the residential program (usually seven or eight at a time) receive special school tutoring for the three months they normally stay. The CC also provides adoption counseling. Besides those teenagers enrolled at Marillac, the CC uses its four social workers for counseling services for teenage parents, although none specializes in this population. In 1982, the CC served 168 single mothers less than 20 years of age.

Abortion services to pregnant teenagers currently are widely available in Worcester. A Planned Parenthood clinic has been providing out-patient abortions since early 1983. Two Worcester physicians perform abortions in their offices and Memorial Hospital does so on an in-patient basis only. Within the FPSCM structure, there is an organization named Worcester Pregnancy Counseling which performs much of the pregnancy counseling in the city. It includes consideration of abortion as an alternative. The ACCESS program does not itself make abortion referrals.

Finally, some effort to expand school-based services is currently taking place. A pilot project at Fanning Trade Vocational High School includes a teen parent support group, vocational training, and special health services. Fanning Trade has long been active in referring pregnant students to the SAM program. The school is now trying to supplement some of SAM's services.

Service Climate

Among the factors shaping the Worcester service climate three central influences repeatedly emerged in our study: 1) the role of medical professionals in identifying service needs; 2) the utilization of university expertise in planning programs, staffing service organizations, and encouraging philanthropy; and 3) the influence of the Catholic Church, the denominational preference of more than half the city's population.

Among Worcester's greatest assets are its excellent hospital and medical facilities. There are 13 general hospitals

in the Worcester area, as well as the University of Massachusetts Medical School and teaching hospital.[13] The tradition of excellence in higher education has also contributed to a supportive service climate. Many service innovations are pilot-tested in the Worcester area by university researchers. Area businesses have come to rely on these institutions for the skilled professional workers necessary to meet corporate needs. The support for social service work is also reflected in a high per capita contribution to the United Way and that organizations' leading role in facilitating community planning and interagency cooperation. There are currently more than 200 non-profit organizations in Worcester, some tracing their origins back to the 19th century.

One of the most important actors in defining the service climate is the Catholic Church. An assessment of its effectiveness in promoting services for pregnant and parenting teenagers depends on one's ideological leanings. The Church's influence has been important in limiting the development of sex education in the public schools, and discouraging the provision of abortion-related services. It has also questioned the efficacy of a purely medical model. The Church has contributed to a community-wide pro-service ethic by developing many excellent programs and has attempted to build networks that have improved services greatly.

Historical Development of Services

The development of comprehensive services to pregnant and parenting teenagers began in the late 1960s when a local foundation, the Allen Fund, gave money to a coalition of community-based organizations that had identified "unwed motherhood" as a significant and widespread problem. A half dozen women--one directly out of graduate school, the others from anti-poverty agencies, the Worcester School administration, the Visiting Nurse Association (VNA), and the YWCA--conducted a needs assessment. The result was a successful partnership among their respective agencies to organize the School Age Mothers (SAM) program to enable pregnant teenagers to complete their high school education. Prior to the founding of the SAM program in 1968, the only special services were offered by Catholic Charities' home for unmarried mothers, Marillac Manor.

The SAM program was initially located at the YWCA, which also was responsible for social services. The Worcester

schools provided instruction and services from its Special Education budget and the VNA offered health care. Initially, the program served a small population that was almost exclusively black because, according to one respondent, "At the time the assumption was that all teenage parents were black." However, as the program attracted additional funders for infant day care and more extensive medical and social services, providers found increasing numbers of whites attracted to the program. What began as a small anti-poverty type program (with model cities grants supporting the project in its early years) soon grew into a large program with an increasingly white, middle-class constituency.

The YWCA eventually lost interest in the program as its board members and program administrators became uncomfortable with the presence of children and pregnant teenagers in their building. In 1975, the Children's Friend Society, a (Worcester area) social service agency established in 1849, replaced the Y as the administering agency for SAM. In its new location at the Worcester Girls Club, the program grew, reaching close to 100 pregnant teenagers per school year at its peak in the late 1970s. Recent cutbacks in its health and infant care components, as well as an increasing reliance on Worcester city revenue sharing funds, have placed the program in financial peril. Nevertheless, it remains a vital part of the battery of comprehensive services available to pregnant and parenting teenagers in Worcester today.

A more ambitious effort to combat teenage pregnancy in the Worcester area was launched by several health providers in the mid-1970s. During that period, Family Planning Services for Greater Worcester (FPSGW), despite some notable controversy over its parent organization's (Family Planning Foundation) administrative and sub-contracting methods, became Worcester's lead agency in developing reproductive health services for indigent women. By 1975, only a few months after the Foundation was declared legally bankrupt, FPSFW became the grantee for most of the federal Family Planning program dollars coming into Worcester through Titles X (Family Planning), XIX (Medicaid), and XX (Social Services).

In 1976, a rising adolescent pregnancy rate was cited by FPSGW as evidence of the need for new services. The director of the agency convened a teen services sub-committee for her advisory board to design initiatives. In 1977, the organization began offering free pregnancy testing and counseling for adolescents and organized teen rap groups. These services were paid for out of general operating funds.

In 1978, the organization received federal CETA and Title X special initiative money which greatly expanded its special services. With CETA dollars FPSGW hired staff, primarily counselor/educators, who were trained and then placed in community agencies serving adolescents. With Title X funds, FPSGW worked on community outreach and education, waging a media campaign that informed teenagers about the risks of pregnancy and the availability of services. Unfortunately, after conducting a broad effort to assess the needs of the teenage population at risk, many sources of federal money dried up. However, the state began to pick up the slack at this time (1978) through Department of Public Health's programs in "adolescent health."

Around the same time a group of six Worcester physicians began meeting regularly to discuss teenage problems. The director of FPSGW joined the group and encouraged it to focus on teenage pregnancy. The Worcester Teenage Pregnancy Task Force, as it came to be known, moved quickly to include social service and educational representatives in its proceedings. It invited the School Age Mothers Program, Catholic Charities, the Worcester Public Schools, and more than a dozen other area providers to participate in monthly deliberations on how to build a comprehensive system of services for pregnant teenagers.

Some dissension occurred over the preferred service model and the identification of a lead administrative agency. Several providers made it known that they wanted to organize programs within their own agencies, and ideological conflicts arose as the organizing process played out. Catholic Charities and the Worcester School Committee were reluctant to support any program that could be construed as favoring or condoning abortion or sex education in the schools. Though they remained on the Task Force, they did not vigorously support the development of the ACCESS services which were eventually funded.

The Task Force was able to settle the turf struggles among its health providing participants by organizing a multi-site service delivery model; it included two hospitals, Hahnemann and Memorial, and one community-based organization, Family Health and Social Services Center. The group also settled on FPSGW, now renamed Family Planning Services of Central Massachusetts (FPSCM), as the program grantee. The group applied for and received Title VI funds from OAPP in October 1979.

The new ACCESS project faced significant barriers in organizing its services. Some members of the coalition (formerly the Task Force) that had supported the application to OAPP were not convinced that the funds were being allocated fairly. There was resistance to the health emphasis of the ACCESS model; some coalition members felt that other needs would not be met. A coordinator for ACCESS was not hired for six months, and the schools were balking at their proposed role. Lula Mae Nix of OAPP urged that the program include school participation, and offered additional funds if the Worcester Public Schools would sign on. However, such cooperation was not secured and ACCESS services developed without significant involvement from the schools.

Some of these concerns found expression when another group of Worcester service providers and planners organized to study teenage pregnancy and parenting service gaps. The Social Services Corporation of Worcester (SSCW), a planning and coordinating agency supported by state Social Services and local United Way funds, worked with a group of providers left out of the ACCESS coalition. SSCW conducted its own needs assessment in late 1979. In contrast to the primary health care emphasis in ACCESS, it focused more on the social and protective services needed by teenagers after delivery. In partnership with the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), the SSCW laid the groundwork for the Teen Parent Program, emphasizing parenting skills, positive identity formation, and child abuse prevention.

Meanwhile, the nascent ACCESS program received an important setback when the Planned Parenthood League of Massachusetts announced its intention to open an abortion clinic in Worcester. The director of FPSCM tried unsuccessfully to get the opening postponed. FPSCM did not itself perform abortions but did offer pregnancy counseling that included consideration of the abortion option. For many, the association of FPSCM with Planned Parenthood was immediate. Said one respondent, "There was guilt by association. Catholic Charities (CC) backed out (of the ACCESS coalition) as did the School Department. They said 'get Catholic Charities and you have us'." Originally, the ACCESS proposal did have support from the Catholic Charities board, but, after the Planned Parenthood announcement in December 1979, the whole environment changed.

There are historical antecedents to the tensions among the schools, the Catholic community, and FPSCM. In the mid-1970s, FPSGW developed a teenage health pamphlet and

distributed it to some teachers and school guidance counselors on the recommendation of a lower level school administrator. The pamphlet mentioned oral and anal sex. Some parents, teachers, and administrators were incensed by what they considered "pornographic material." Other such incidents have occurred over the years, widening the gulf between FPSCM and the religious community. The schools have often served as the lightening rod for these issues.

Since 1980, the ACCESS program has been very successful in its development of a health-based comprehensive service model for pregnant and parenting teenagers. A coalition of community providers continues to meet regularly and new service components for pregnant and parenting teens are being added. Catholic Charities and the School Department remain active within the coalition, but further efforts to involve these organizations in service provision have been modest. One initiative by the Children's Friend Society Services' Young Parent Initiative seems promising. It seeks to formalize linkages among the programs currently administered by FPSCM (ACCESS), the MSPCC (Teen Parent Program), and the partnership between Children's Friend and Worcester Public Schools (SAM). Children's Friend, which has a modest outreach and referral program, will act as a central administrator and referral source. The four collaborating agencies will identify service gaps through a community advisory council and will develop individual service plans at intake based on team recommendations.

Factors Enabling and Hindering Service Development

Resources. Worcester service providers have grown accustomed to joint, interagency planning. The involvement of area planning agencies such as the United Way and the Social Services Corporation has aided service development. Planning has, at times, been contentious, and not all participants have been satisfied. Still, it is important to point out that agencies such as Catholic Charities and the Worcester School Department continue to participate in coalitions and group decisionmaking. Very often agency executives themselves participate in this process. For example, a group of several program directors called "Worcester Pregnancy Providers" meet regularly over breakfast with Worcester area political figures to make their case for greater public sector support.

Another vital resource for Worcester area providers has been their access to a multiplicity of funding sources in developing services. Federal, state, local, and private foundation funds have been used. Innovative sub-contracting

and collaborative agreements between agencies have also helped greatly. The ability to secure and use funds flexibly is additional evidence that Worcester providers have attained an unusual level of sophistication.

The close proximity of the agencies within the downtown area and the existence of a relatively stable staff facilitate interagency collaboration. There are dozens of private non-profit agencies located in a small downtown area. Most administrators and service providers we talked with had been with their agencies for more than ten years. An informal but functional service culture has developed based on personal familiarity.

Leadership from many different areas of specialization has facilitated service development. Community change-oriented providers, medical school professors, and physicians, nurses, social workers and planners have all contributed. Organizations generally support each other when they apply for funds. Worcester providers have been instrumental in educating the area media, especially the newspapers, to the importance of services; with a few notable exceptions, good coverage and positive publicity has usually resulted. They also provided leadership during the initial years of the statewide Massachusetts Coalition on Pregnant and Parenting Teens (MCPPT), which was instrumental in supporting the recent DSS Young Parent's Initiative legislation; a Worcester woman chaired the Coalition at that time. The city's woman mayor, who serves in a largely ceremonial but prominent post, has spoken out forthrightly on women's issues.

Constraints. Evaluation and follow-up are potentially useful for service planners and advocates, and are required by funders for the ACCESS and Children's Friend/Young Parent Initiative programs. Such evaluation efforts do not extend to (SAM) the school-based program, nor do the state and federal evaluation requirements provide common grounds for assessment. While planning and evaluation should, in theory, be closely linked, in Worcester as elsewhere, the two appear never to meet.

One of the most serious constraints to service delivery in Worcester lies in the separation of planning and evaluation methods. However, it is not the traditional technical problem identified above--one that could be solved by comparable data forms or centralized interagency planning. The most difficult obstacle has always been the struggle over the goals of comprehensive services. Although many providers have devoted considerable time to collaborating on service development, they

have not been able to agree on a long-term strategy for preventing unintended pregnancies and serving pregnant teenagers and their children.

The tensions among Catholic Charities, the School Department, and Family Planning are ideological ones that rest primarily on the abortion issue. Such conflict appears inevitable as long as FPSCM is identified as the primary advocate for comprehensive services. Gaining other institutional support is essential to bridge the gulf created by the divisive abortion issue. For example, school administrators active in supporting programs for pregnant and parenting teenagers, also have wives who are leaders in the Worcester "Right-To-Life" organization. They cannot help being sensitive to the placement of responsibility with an agency such as FPSCM.

The Worcester School Department, having lost its ability to utilize Special Education funds in the SAM program, appears to be withdrawing its support from SAM. Help does not seem forthcoming from other state or local auspices. For example, no infant care funding was attached to the recent DSS initiative. Unlike California and Michigan, Massachusetts has not been able to link any day care policies for this population with sustained school attendance. Unless new funds become available, the SAM program may have to close down in the near future. Its increasing reliance on city general resources and United Way contributions makes it particularly vulnerable.

In addition to developing a stronger, more financially stable school-based program, Worcester is in need of increased funding for its ACCESS comprehensive program and the other service components. The ACCESS program was the only one of the three Massachusetts comprehensive programs, formerly funded by OAPP Title VI, not to receive Title XX Family Life Demonstration grants. It is presently searching for support for its administrative overhead. Both Children's Friend and the MSPCC have increased their reliance on private fundraising as public funds have dried up. Like many other cities in our study, with or without comprehensive services, Worcester programs are now on the brink of financial collapse.

Conclusions

Comprehensive services for pregnant and parenting teenagers exist in Worcester although they are currently threatened. The medically-based ACCESS program has effectively linked pre and postnatal health care services to social casework and advocacy services.

The school-based SAM program is beginning to lose students because of budget cuts. This illustrates the difficulty of sustaining school-based programs without special state funding and Department of Education support.

The programs do seem to be making a difference. The service penetration rate appears high compared to other cities in our study. The issue of teenage pregnancy and parenthood now appears to be prominent on the community agenda, and many groups are working to improve services. Their challenges are to secure continuing support and to find a common ground to enable diverse groups to cooperate.

Worcester has a supportive service climate, unlike Lowell, the city with which it was matched. This is manifested by its history of philanthropic support and tradition of community planning. Program administrators maintain close working relationships despite ideological differences. There is little turnover in leadership. The strong United Way organization also plays a pivotal coordinating role.

The controversy over abortion has carried over to conflicts over services to pregnant and parenting teens. Some services have been constrained by the stigma attached to teen pregnancy.

Like other study sites, Worcester has drawn upon multiple funding sources, and this has contributed to program instability. It has had the benefit, however, of flexible local funding, from foundations and the United Way, that has helped some programs manage the transitions from one funding source to another.

III. LOWELL

Lowell is one of several depressed older cities located along the Merrimack River, north of Boston and just south of New Hampshire. Since the late 1970s, this city of 92,418 has tried, with limited success, to capitalize on its industrial history by developing its abandoned canals and textile mills into a tourist attraction.

The 1980 U.S. Census reported median family income in Lowell to be $17,942, compared to $21,166 for Massachusetts. Of Lowell's families, 11.3 percent were below the poverty level. This compared to 7.6 percent of families in the state. Just over 41 percent of all workers in Lowell were employed in manufacturing industries, the highest proportion by far of any city in the study. Sixteen percent of the city's workers had professional or managerial jobs ("managerial and professional specialty occupations"), an unusually low figure. Only 10.4 percent of persons over 25 in Lowell, compared to 20 percent in Massachusetts, had completed four or more years of college, while 57.7 percent were high school graduates.

Lowell's geographic location constrains development of some services, while it also provides certain benefits. The city is less than 15 miles from Boston's beltway, Route 128, and less than 30 miles from Boston itself. This proximity to a large urban center is convenient in some ways for Lowell's residents, but reduces the city's own ability to attract major commercial or industrial development. One of the few large employers to establish and maintain corporate headquarters in Lowell is Wang Laboratories, a progressive high technology company with over 6,200 workers in the city and many more in the surrounding suburbs.

Lowell's residents are dependent on other metropolitan areas not only for much of their employment and shopping, but also for some health services. For example, there is no abortion clinic in the city, and because two of the three local hospitals have Catholic sponsorship, few hospital abortions are available.

Schools and housing, perennial concerns in many large cities, are currently major issues in Lowell. Former Senator Paul Tsongas, a native of Lowell, spurred formation of a task force that recently completed a study of the school system

and made recommendations for its improvement. The task force, which consisted largely of specialists from outside the city, did not encourage significant community involvement. Its report has aroused the dissatisfaction of city officials, who simultaneously are deemed responsible for the system's flaws and are supposed to implement the panel's suggestions. The shortage of decent low and moderate income housing is being attacked by the Coalition for a Better Acre, a grass-roots organization based in one of the city's poorest neighborhoods, the "Acre," which has traditionally housed its newest immigrants--at various times--Irish and Greek, and now Puerto Rican. The Coalition has complained that the development of the city's Urban Park not only has not benefited the poor, but has hurt them by drawing away police and other basic services. The group has succeeded in attracting private funds to help improve the neighborhood without displacing current residents. Their work is opposed by some city councilors who would prefer to gentrify the area.

Lowell has a particularly high rate of births to teenagers. In 1980, there were 304 births to women under 20 in Lowell, 105 of which were to women under 18. While 19.1 percent of births in Lowell were to teenagers (under 20), only 10.7 percent of all births in Massachusetts were to this age group.

Current Services for Pregnant and Parenting Adolescents

Since January 1983, the Massachusetts Department of Social Services (DSS) has provided funding to Healthworks, a large, multi-site family planning agency formerly known as Family Planning Incorporated, to serve pregnant and parenting adolescents. Healthworks is based in Lowell but also operates in Lawrence and Haverhill. Lawrence, with a population of 63,000, is about ten miles from Lowell; Haverhill, a town of 46,000, is another 60 miles away. The "pregnant and parenting" program operates separately in all three cities. This discussion describes only the services based in Lowell.

Healthworks has a good reputation as a family planning agency. It provides well-regarded counseling services as a part of its complete family planning program and has run separate clinics for teenage patients since the early 1970s. As of 1984, it has an agency-wide budget that exceeds a half million dollars and serves 10,000 patients per year, about half of whom are in Lowell. The Healthworks program for

pregnant and parenting teenagers is not a comprehensive one according to our criteria because it lacks direct linkages with both the educational and health care systems. This Healthworks component (which does not have a separate name) employs one fulltime social worker and one half-time paraprofessional, and serves about 40 clients, approximately one-third of whom come from outside the city.

The workers in the "pregnant and parenting" component primarily offer counseling and support services, and secondarily provide advocacy services, referrals and education around health and child welfare issues. Because transportation represents a major obstacle for clients, the workers conduct many home visits. They also run two groups, one for pregnant women and one for mothers, but fewer than half the pregnant and parenting clients are enrolled in a group and an even smaller number attend regularly. Most referrals to the program come from within the agency once a patient has had a positive pregnancy test. Additional referrals come from the Prenatal Clinic at Lowell General Hospital, the Teen Clinic at St. John's Hospital (described below), the Lowell DSS Office, or occasionally from one of the high schools in the area.

Lowell General Hospital runs the city's only prenatal clinic for limited income or Medicaid-eligible women. The clinic provides no special hours for teenagers. Approximately 80 teens are seen each week at the clinic, about 20 of whom regularly see clinic social workers. Aside from these social work services, which are somewhat more extensive than those provided for older women, only one adjustment in clinic procedure is made for adolescents. The hospital has had a policy of refusing to see adolescents who could neither pay nor qualify for Medicaid. Now, rather than seeing a financial officer immediately on her first visit to the clinic, an adolescent, if she is considered a "problem case" by the referring agency, may see a social worker first. The social worker then helps the patient to negotiate with the hospital so that the young woman can receive services. This new system was worked out, with some difficulty, by the nurses at the St. John's Teen Clinic, a worker from the Lowell General Prenatal Clinic, and a representative of the state Department of Public Health. Very few young patients (only about one per week, according to the social worker involved) have received services under this system.

St. John's Hospital, one of two Catholic hospitals in Lowell, has operated a Teen Health Service since 1974. Because the hospital has no maternity service the clinic

provides no prenatal care. The staff does pregnancy tests and counseling, then refers to other providers for follow-up care.

St. Joseph's Hospital closed its prenatal and maternity services in 1981, and thus provides no regular care for adolescent mothers.

Lowell High School also provides no special services for pregnant students. At Greater Lowell Regional Vocational Technical High School, a nurse from St. John's Teen Clinic and a "Chapter I" school counselor conduct a group for pregnant and parenting students. Attendance is voluntary and no credit is given for participation. The administration of the school, which has 2,300 students, argues that graduation and certification requirements--including not only classroom work but also shop hours--limit the alternatives available to pregnant students.

The Lowell YWCA, with funding from the Regional DSS Office and a private foundation, provides a variety of services to about 30 low-income mothers, most of whom are in their late teens and early 20s. None are in their first pregnancies, and none are currently enrolled in school. They therefore represent a population which differs somewhat from that served by the other programs described in the study, although both the Y's orientation and its attempts at working collaboratively with other agencies make it similar to many of those programs. The Y, which is located in a middle-class neighborhood and has traditionally served a white, middle-class population, has embarked on an outreach effort in a housing project and in the "Acre." It is providing individual and group counseling as well as advocacy and educational services through its Family Support Center. It has organized a GED satellite program on site at the housing project; more than half its clients are black or Hispanic.

One other agency which provides some services to pregnant teens is the Florence Crittenton League of Lowell, which has existed for 135 years. It has not operated a maternity home since the early part of this century. The Lowell and Boston Crittenton agencies work cooperatively, with the Boston facility running a maternity home and the Lowell agency concentrating on adoptions. Because of its adoption focus, the Lowell Crittenton agency's major contribution is in pregnancy counseling (but not "abortion counseling"). The program does no outreach, nor does it make any significant effort to network with other local providers. In 1982, the Lowell Crittenton facility placed 50

North American (white) babies, as well as a small number of South American (white) and interracial babies. Over 90 percent of its clientele, both adoptive and birth parents, are white.

Service Climate

Service providers in Lowell expressed considerable hostility--against "the system" and against one another--on a variety of subjects. For example, one agency official repeatedly criticized the motives and efforts of fellow professionals, ranging from hospital board members and physicians to school board members and state funding agencies.

Although several individual program components exist in Lowell, no one has ever succeeded at developing a comprehensive program linking health care and schooling with counseling services. Nor has anyone put together a viable coalition of providers to exert pressure on public agencies to improve their services for pregnant adolescents.

Virtually no service provider interviewed in the course of this study lived within Lowell. Some lived in the city's immediate outskirts, but others lived a considerable distance away. Several expressed pride and relief that they did not have to live in the city.

Historical Development of Services

In the fall of 1972, a Boston University social work student was given a community organization fieldwork placement at the Dr. Harry C. Solomon Mental Health Center in Lowell. The Center in turn assigned her to begin a drop-in center and support group for girls in one of the city's largest public housing projects. It was soon found that other needs of the girls were not being met in the community, particularly if they became pregnant. This finding, along with the results of a small research project (the "First Baby Project") conducted by the local Mental Health Association and the Solomon Mental Health Center, led those two agencies to encourage the student intern to focus on serving pregnant and parenting adolescents. In February 1974, she initiated the Premature Parenthood Program (PPP). Under her leadership, the program grew steadily until her departure in 1978 when it was serving between 220 and 240 young women per year in "educational supportive parenting groups."

Each group met twice a week in a 12-week series with the option of re-enrollment for a second series. The program provided transportation and babysitting during group sessions, outreach and crisis intervention services and extensive home visiting. It operated out of several different centers, trying to teach concrete skills and to connect participants with service providers in the community. The program also made a major effort to recruit and when necessary train minority, especially Hispanic, workers. Funding came from the Department of Mental Health and from the Massachusetts Office for Children.

When the founding director left the PPP in 1978, the program had been incorporated into the budget of the Mental Health Center, and seemed to be in a stable situation. However, her immediate successor left within a year. The third director continued to run a similar program but with a greater emphasis on counseling and somewhat less emphasis on education. She continued to seek out Hispanic workers, but reduced the use of program evaluation. During the third director's tenure the PPP was consolidated into "children's outpatient services" within the Mental Health Center. All the staff members of that unit were employees of the Mental Health Association, which was physically located within the Center until 1980. Following a major upheaval in the Mental Health Center, the Mental Health Association and all its employees were evicted. Charges of conflict of interest and ineffectiveness resulted in replacement of the Center's entire management and efforts to replace specialized programs with more general services. A by-product of this upheaval was the demise of the Premature Parenthood Program. By 1981, the PPP was abolished. Although other service providers regretted the loss of the program, they did not coalesce on its behalf. Nor is it clear that they could have affected the outcome if they had. One problem with the program was its location in a mental health agency where its services were considered peripheral to the agency's central mission.

Since the termination of the Premature Parenthood Program, the services in Lowell have remained largely as described above under "current services." Family Planning Incorporated changed its name to Healthworks in 1980, and has provided more substantial services to pregnant and parenting adolescents since receiving DSS funding. Group discussions for pregnant and parenting students have begun at Greater Lowell Vocational Technical High School, but no concrete educational services addressing the needs of this population have been or are being offered. Neither are any special health services being offered for pregnant

adolescents. Development of comprehensive services is not a subject that Lowell's providers even discuss today.

Factors Enabling and Hindering Service Development

Resources. Potential resources that were untapped by administrators of the Premature Parenthood Program were technical and financial assistance from the state level. In the late 1970s, the Massachusetts Department of Public Health (MDPH) employed a specialist in adolescent health who made it her mission to encourage services to pregnant and parenting teens. Apparently, because the PPP was funded almost exclusively by DMH, the program and this potential source of support (MDPH) never made contact. The state's Department of Social Services was newly organized and did not receive funding for its Teen Age Pregnancy Initiative until after the collapse of the PPP.

Ironically, the area's relatively high rate of births to teens and its dearth of services increase its potential for receiving funds. Proposals from Lowell to the state level for services to this population cannot help but receive attention because the city's fertility rate for women under 18 was the third highest in the state in 1981. (Lawrence, also served by Healthworks, had the state's highest rate.)

Constraints. The factors constraining service delivery in Lowell are numerous, ranging from its demographic composition to its geographic location and leadership.

The city's unusually small proportion of professional and managerial workers reflects both its occupational and its residential structure. Not only is there a dearth of executives and professionals who work in Lowell, but many of those who hold such jobs choose to live elsewhere.

Lowell's location near Boston and its suburbs also makes it difficult for the smaller city to draw attention to its needs, and to attract the resources necessary to meet them. For example, since Lowell lacks local foundations, its providers must compete for funds with Boston-based programs among Boston-based funding agents. An additional hindrance is the fact that Lowell does not have its own United Way organization. Its agencies receive funds through the Merrimack Valley United Way in Lawrence.

The city made a major effort to encourage Wang Laboratories to develop its new headquarters building there.

granting a variety of concessions in the process. The new Lowell National Historical Park (established in 1978) brings thousands of visitors to the area. While both Wang's 6,000 employees and whatever tourist trade the Park generates have improved Lowell's "image," neither has had much impact on social services. Some argue that these efforts have diverted attention and resources from the low-income community.

Lowell has also lacked leadership adequate to the task of developing comprehensive services for pregnant and parenting adolescents. Administrators have either been uninterested in this service population, or unwilling to share control in cooperative efforts. This last factor, willingness to permit other agencies to retain some control over clients and program format, has appeared in other study cities as an important determinant of interagency cooperation.

In 1980 Healthworks did bring together a task force to try to write a proposal for federal funds. Representatives of other agencies, however, expressed concern that Healthworks was more interested in control than in cooperation, and the task force was eventually allowed to disolve.

Conclusions

Education and health administrators in Lowell have not focused their energies on responding to the particular needs of school-age mothers. The special, but non-comprehensive, programs that have developed have been operated by agencies not usually offering such services, and with somewhat idiosyncratic funding sources. The Premature Parenthood Program, sponsored by the Mental Health Association and the YWCA's Family Support Center, funded partly by a private foundation, are illustrations. Healthworks, a family planning agency using state social service funds, is somewhat more "traditional," but does not take the lead in coordinating services.

In contrast to Worcester, there is an extreme insufficiency of basic services in Lowell. Numerous providers mentioned, for example, the inaccessibility of routine prenatal care. Only Lowell General Hospital provides care for those who lack insurance or the ability to pay, and several informants expressed dissatisfaction with that situation. Others noted the inadequacy of the local school system in dealing with minority students and those with special problems.

Agencies struggling to sustain a minimum level of services might understandably lack enthusiasm for developing specialized services for a particular sub-population.

Few, if any, adolescents in Lowell receive a full array of health, educational, and social services during their pregnancies. Those who do must create their own "linkages." The likelihood that this situation will improve in the near future is remote.

While Worcester has a tradition of cooperative community planning, many Lowell administrators see their agency counterparts only as competitors. Lowell lacks a community planning mechanism like Worcester's United Way, and has few local resources for program support. It also lacks a core of professionals who might, as in Oakland, capitalize on its impoverished status to secure state and federal funds.

NOTES

1. Boston Globe, March 13, 1984.

2. Virginia Cartoof. "Characteristics of the population served by the Young Parent Initiative." Boston, MA: Massachusetts Department of Social Services, December 1983, p. 1.

3. Ibid, p. 2.

4. St. Margaret's Hospital, an OAPP grantee, recently came under investigation for allegedly using federal funds to develop sex education materials promoting values of the Catholic Church.

5. Virginia Cartoof and Lorraine V. Klerman. Massachusetts' Parental Consent Law: A preliminary study of the law's effects. Massachusetts Journal of Community Health, Spring/Summer 1982, 14-19.

6. Massachusetts Coalition on Pregnant and Parenting Teens. Coalition Newsletter. Worcester, MA: MCCPT, Spring 1982, p. 3.

7. Senate Panels' proposals focus on infant health. Boston Globe, June 3, 1984, p. 25.

8. Ibid, p. 26.

9. Worcester Shedding Smokestack Image. New York Times, September 25, 1983.

10. Massachusetts Department of Commerce and Development. Massachusetts profile of Worcester SMSA. Boston, MA: Department of Commerce and Development, 1976.

11. ACCESS Prospectus. ACCESS, a service for pregnant teens. Worcester, MA, 1983.

12. Ibid, p. 1.

13. Massachusetts Department of Commerce and Development. Massachusetts profile of Worcester SMSA. Boston, MA: Department of Commerce and Development, 1976, p. 6.

Chapter 5. Michigan

I. STATE POLICIES AND PROGRAMS

Michigan has for several generations been both relatively wealthy and generous in terms of socialized welfare provisions. Its labor force has been strongly unionized, enjoying good wages and fringe benefits. The recession of the early 1980s hit Michigan hard, however. The nature and timing of the economic crisis described below mean that data from the 1980 U.S. Census, which serve as useful comparative indices for the other study states, give less valuable pictures of the current status of Michigan's population. They show a state in which median family income was relatively high (eighth highest among all states), and the proportion of families with incomes below the poverty level was relatively low.

Unemployment in the state rose from 7.9 percent as of the end of 1979 to 17.3 percent, the second worst in the nation, three years later. (The rate for the U.S. rose from 8.3 percent to 10.5 percent during the same period.[1]) By early 1983, more than 740,000 people in Michigan were out of work.[2] For many, loss of a job means loss of health insurance. Blue Cross and Blue Shield of Michigan reported a drop of more than a half million participants between 1979 and January 1983. Medicaid[3] rolls increased by only 106,000 during the same period. By early 1983, nearly 15 percent of Michigan's total population was receiving some form of public assistance. Yet, there is a significant gap for a middle-class family between the exhaustion of unemployment benefits and eligibility for Medicaid or public assistance, for which one must be truly destitute. The state has therefore had a large number of medically indigent who could not afford to pay for their own care, but who failed to qualify for help.

Large-scale unemployment in the automobile and related industries during the early 1980s, by simultaneously reducing tax revenues and escalating the demand for public services, helped fuel a state budget crisis. Cuts in federal programs contributed to Michigan's problems; the state was running a $900 million deficit by early 1983 and further cuts were imminent. Michigan's crisis may abate as the automobile industry revives, but when or whether the state will regain its former prosperity is uncertain.

Current Services for Pregnant and Parenting Adolescents

Michigan is one of very few states that has passed legislation earmarking funds specifically for programs that serve pregnant and parenting adolescents. The past four years illustrates the traumatic impact of fiscal stress on the implementation of policies that have been well-designed and that many have viewed as a "model" for the nation.

Public Act 242. Michigan, like California, has two separate pieces of legislation under which special services for pregnant and parenting teenagers are funded. Both are under the jurisdiction of the state Department of Education. The first, Public Act 242, enacted in 1970, prohibits schools from expelling students because of pregnancy. Public Act 242 also states that: "A school district may develop, provide and receive financial reimbursement for an accredited alternative school program...if:

(a) The program is taught by a person holding a valid Michigan teaching certificate.

(b) The educational program is approved by the state Department of Education as equivalent to the regular school program and provides for health counseling, child care instruction and services, social services and prenatal instruction within the resources of the district providing the program."[4]

Under these regulations, a school district establishing such a program is eligible for reimbursement from the state for the salary of the teacher assigned (at a ratio of one teacher to 20 students). The reimbursement formula was set at 75 percent of the teacher's salary, or a maximum of $8,100, reflecting salary levels in 1970. It has not been increased. In 1971-72, the legislature authorized $300,000 for this purpose. The funds authorized, although they were increased to $700,000 for 1975-76 and several years thereafter, have not kept pace with the growth in the number of programs. The state Department of Education has dealt with the shortfall in funds by reimbursing all districts with programs that request it, but at a lesser rate. In 1981-82, for example, by which time the appropriation had been reduced to $558,000, 66 school districts were reimbursed at approximately $4,000 per teacher.[5] The Department lacks the resources to monitor these programs and once a district has begun to receive salary reimbursement funds, it is unlikely that its compliance with the regulations will be examined.

The "Model Site" Program. The second relevant piece of legislation is Section 93, Part 2, of the state School Aid Act, passed in 1979. It allows the Department of Education (DOE) to provide selected districts with additional funding to develop "model" services for pregnant and parenting adolescents. The goals are:

1. To meet the complex needs of pregnant adolescents and young parents and their children.

2. To decrease the incidence of dropouts among pregnant adolescents and school-age parents through a comprehensive program of education, health, mental health, and social services.

3. To prevent repeat pregnancies in the adolescent years.

4. To prevent the cycle of premature parenthood and aberrant parenting.

The appropriation for this "model site" program has been $240,000 per year which supports between three to eight programs (school districts). This state money has been used at the local level mainly to purchase non-educational services such as counseling and child care for participants, that is, to create "comprehensive" programs.

This program has been developed and supervised by the state's Inter-Agency Committee for Services to High Risk Children and Their Families, discussed below. In 1979-80, the first year of funding, the Inter-Agency Committee made grants to three local districts, Kalamazoo, Lapeer, and the Wayne County Intermediate School District. In 1980-81, three different sites (Willow Run in consortium with Ann Arbor and Ypsilanti; Detroit; and Leslie) were selected. The sites selected for this second year aroused controversy because the first year recipients had been led to expect that they would be refunded. In 1981-82, the Inter-Agency Committee determined that sites should have more than one year to develop their programs. Subsequently, all of the previously funded programs except Lapper, which opted not to be included, were refunded, and Lansing, Oxford, and Highland Park were also included "to get more of a cross-section of rural, suburban, and metropolitan school committees in Michigan."[6] The Committee has continued to fund the same eight programs for the past three years.

The Departments of Social Services, Mental Health, and Public Health have participated closely (see below) in the development and implementation of the "model site" program. While neither Social Services nor Mental Health has developed its own special programs or services for pregnant or parenting adolescents, administrators in these Departments are aware of the need and have expressed a commitment to serving this population.

IPO. The Department of Public Health has administered an Improved Pregnancy Outcome (IPO) project for pregnant adolescents. During its five years of operation (1978-83), Michigan's IPO program developed demonstration projects in two urban and two rural areas with high infant mortality and high adolescent birth rates. The project's goals were to: reduce the incidence of unplanned adolescent pregnancies and improve the outcome of pregnancies that did occur; increase the availability and accessibility of services for prevention and care of adolescent pregnancy; and educate adolescents, their parents, and service providers about risks, consequences, responsibilities, and services related to adolescent pregnancy. The project established a clearinghouse to assemble and disseminate information on these issues. In cooperation with the Department of Education, the IPO project also surveyed Michigan's school districts to assess provision of reproductive health education, including family planning information, that is, to assess the extent of implementation of Public Act 226 (see below). Michigan was the only state that elected to use its IPO funds specifically for pregnant adolescents. No community or school district has received both IPO and DOE "model site" funding.

Historical Development of Services

By the late 1960s, four cities in Michigan had special school-based programs for pregnant adolescents. Each program--Detroit, Flint, Saginaw, and Kalamazoo--had its own source or sources of funding. These included Special Education money from the state, Title I of the federal Elementary and Secondary Education Act, and the Mott Foundation. The directors of these programs met at a small federally-sponsored regional conference held in Detroit in 1967, and at a state conference sponsored by the Mott Foundation in Flint in 1968. They saw a need for mutual support since, as one member of this group observed, "In those days, people looked down on us" for serving a stigmatized population. They also sought to develop a new funding source from within the state. The director of

Detroit's program, Nancy Boykin, approached her local legislators, and finanally got the ear of a representative from the wealthy suburb of Grosse Pointe. With this aid, Ms. Boykin drafted legislation that would forbid exclusion of pregnant students from schools and would provide state funds for local districts to hire special teachers. (Her original drafting of the bill would have required creation of special programs.)

The local service providers founded the Michigan Association for School Age Parents (MASAP) in April 1970, becoming the first such state coalition in the country. (When the organization affiliated several years later with the National Alliance Concerned with School Age Parents, NACSAP, it became the Michigan Association Concerned with School Age Parents, or MACSAP). In December 1970, Public Act 242 was passed and signed by the Governor. Further efforts were necessary to insure that funds would actually be appropriated. The newly formed MASAP played a crucial role. The Speaker of the House, who had worked to assure the failure of a liberalized abortion law, was the focus of MASAP's lobbying efforts. The Speaker was receptive to the argument that if young women were not to be permitted abortions, then services should be provided for them. The legislature appropriated funds beginning in 1971, and in response, programs began to sprout "like mushrooms," according to an informant.

Beginning with his appointment in 1969, and through the mid-1970s, Dr. John Porter, the state's first black Superintendent of Public Instruction, was supportive of MASAP's efforts. While he did not take any extraordinary steps with respect to pregnant students, he did listen to the lobbyists, and show them where to direct their efforts. Several years later, when NACSAP was looking for a school superintendent to address a 1975 national conference on "defining the problems" of school-age parenthood from an educational perspective, the Michigan contingent suggested Dr. Porter. He accepted the invitation and by attending, he became aware of the vigorous nationwide efforts in which service providers and by this time the federal government were engaged. Porter pledged to his audience in Denver that he would mobilize an interdepartmental effort in Michigan to improve services for pregnant adolescents. The new enthusiasm of Porter and of other conference participants was mutually reinforcing.

Before the end of the year Dr. Porter convened a School Age Parenting Task Force which included 16 service providers

and staff from the Departments of Public Health, Mental Health, Social Services, and Education. (A representative from the state office of Management and Budget joined the group later.) This Task Force initiated the development of a model of services for school-age parents. Its recommendations led to the subsequent establishment of the Inter-Agency Committee for Services to High Risk Children and Their Families which, despite its name, focused primarily on services to pregnant adolescents. The Committee had the approval of the heads of the departments involved in the Task Force, and included many of the same staff people. It also had a staff of its own, supported by a grant from the Administration for Children, Youth and Families of DHEW. By 1976, Dr. Porter was prepared to tell the next Annual NACSAP Conference how "A State Education Agency Acts on School-Age Parent Needs."

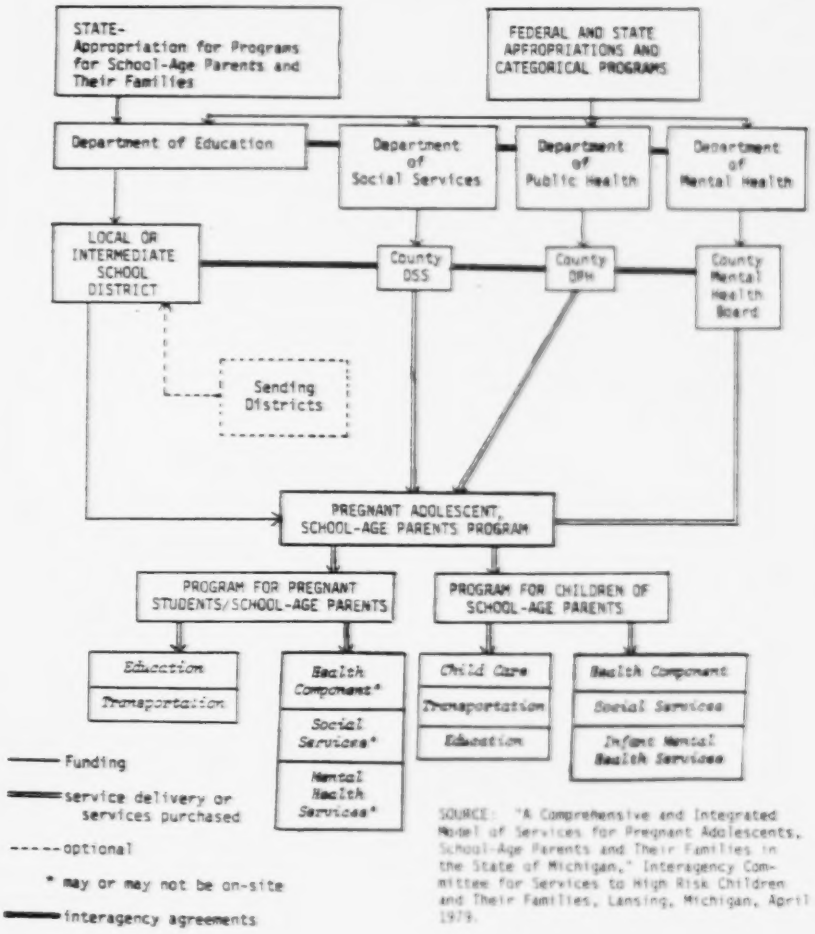
In April 1979, the Inter-Agency Committee published "A Comprehensive and Integrated Model of Services for Pregnant Adolescents, School-Age Parents and Their Families in the State of Michigan," and recommendations for its implementation. Figure 5-1 presents the mechanism the Committee anticipated would provide local funding for the non-educational components. State funds would go to the Department of Education, which would then allocate it to local or intermediate programs which would achieve "comprehensiveness" by providing some services and purchasing others. Under this system, additional funds would be expended by the state directly for local school districts and indirectly for services provided by mental health, social services, and day care agencies.

The model, in the form of Section 93, Part 2, of the State School Aid Act, was legislated in 1979. It was intended to be "demonstrated" in a few districts for a trial period, then expanded to all interested districts. Michigan's financial crisis intervened, however. While the "model sites" program has not been eliminated or even cut back, it also has not expanded beyond its "demonstration" phase.

The Inter-Agency Committee which has worked since the mid-1970s preparing guidelines, selecting sites, lobbying and monitoring, is unusual in a number of respects. The same staff members have represented the Departments of Mental Health, Public Health, and Social Services from the earliest days of the initial Task Force. Responsibility for the program within the Department of Education has shifted numerous times, along with Education's representation on the

FIGURE 5-1

PROPOSED FUNDING AND
DELIVERY OF SERVICES TO PROGRAMS FOR PREGNANT ADOLESCENTS,
SCHOOL-AGE PARENTS AND THEIR FAMILIES



SOURCE: "A Comprehensive and Integrated Model of Services for Pregnant Adolescents, School-Age Parents and Their Families in the State of Michigan," Interagency Committee for Services to High Risk Children and Their Families, Lansing, Michigan, April 1979.

Committee; however, because other departmental Committee members have remained the same, there has still been consistent Committee supervision of the funding processes. None of these departmental representatives began with a particular interest in adolescent pregnancy, although each one had a related concern. For example, one representative had an interest in families, and family policy; another had a particular interest in prenatal care; a third was concerned with infant mental health; and a fourth with sex education. Each person, however, developed a major interest in and commitment to the work of the Committee itself. Dr. Porter seems to have extracted from his counterparts a commitment to making the cooperative effort work, and thus each person was chosen with care by her (they are all women) superior.

The Task Force and Inter-Agency Committee also are part of a larger picture of substantial cooperation between state agencies. For example, in 1977 the legislature passed and then-Governor Milliken signed into law Public Act 226, which legalized the teaching of reproductive health, including family planning, in the public schools. This statute also required the state Board of Education to formulate guidelines for implementation "in cooperation with the Departments of Public Health, Mental Health, and Social Services."[7] The Special Task Force on Reproductive Health, Family Planning, and Venereal Disease that was created in response to this legislation included several of the same individuals who were already working together on the Inter-Agency Committee, as well as numerous other university-based specialists and local educators.

Public Law 226 that permits birth control instruction in public schools, according to one report, "did more than place the state ahead of most of the nation on the subject; it placed Michigan somewhat ahead of itself."[8] Until this law was enacted, Michigan was one of only two states that actually forbade mention of contraception in classes. The 1977 legislation does not require that districts provide instruction in family planning, but it does explicitly permit them to do so. Any local district that chooses to teach reproductive health must abide by state Board of Education criteria for teachers, establish a local advisory board, and adhere to parental notification procedures.[9] Each local district may either adopt guidelines (i.e., curricula) promulgated by the state Board of Education, or develop its own. Abortion may not be "considered a method of family planning" or "taught as a method of reproductive health."[10]

The controversial nature of the material included in the reproductive health curriculum combined with Michigan's fiscal crisis have led to spotty implementation at the local level. Many districts have lacked the funds to establish new programs that would meet all the criteria of the legislation--including hiring of qualified staff. Lack of staff and resources at the state level have also reduced the ability to provide technical assistance and monitor the local districts.

Conclusions

Michigan was among the first states in the nation to enact legislation providing funds for special programs to serve pregnant adolescents. As of 1982-83, there were 67 programs, of varying degrees of comprehensiveness, in school districts throughout the state. Although local execution of the service model developed by the state Inter-Agency Committee remains the exception rather than the norm, approximately 3,000 students (out of 12,000 school-aged pregnant adolescents) received some kind of services that year.[11] Nearly 1,000 of those were served by "model site" programs.[12] Michigan's severe fiscal distress accompanied by the major service needs of much of the population, has reduced the advocates' ability to lobby for increases. In fact, lobbyists came to an agreement in recent years that they would not ask the legislature for anything. The consensus has been that if advocates made any special requests, drawing attention to these programs, they might be wiped out entirely. The strategy has been successful; while the state's education budget has been cut dramatically, neither the teacher reimbursement nor the "model site" funding has been touched.

Services to pregnant teens in Michigan are almost exclusively school-based. Initiative is in the hands of educators in nearly every community, and other professionals do not often take leading roles. This situation has associated advantages and disadvantages, as will be apparent in our discussion of local programs in Saginaw and Kalamazoo.

Unlike most other states, Michigan has seen genuine interagency coordination at the state level on this issue. If "normal" budgetary times do return, Michigan has an excellent model for development of comprehensive services on a statewide basis.

II. KALAMAZOO

Located in Southwest Michigan, Kalamazoo is about 125 miles from Detroit and slightly farther from Chicago. Kalamazoo's progressive heritage and civic pride are manifested in many ways. It was one of the first mid-west cities to have its own symphony orchestra, civic theater, art center, and nature center, and was among the first to adopt the city manager form of government; it was also the first to establish a downtown pedestrian mall.[13] Three colleges and a state university are located in Kalamazoo. Its population of 79,722 was 81 percent white and 15.6 percent black in 1980, while the population of its Standard Metropolitan Statistical Area, 279,129, was 90 percent white and 7.5 percent black.

Kalamazoo's school system served 14,181 students in 1979-80, of whom about 34 percent were black. The city's schools were desegregated by court order in 1971. The process was not traumatic, but neither was it entirely successful. As one black informant commented, "We have desegregated; we are not integrated." About 20 percent of the school population is black.

As in many school districts, there has been considerable turnover in leadership since the 1960s. The system has had 11 superintendents in the past 25 years. The hirings and firings of some of these created considerable turmoil in the community. Indeed, in the mid-1970s six school board members were recalled by the voters because of their support for an unpopular superintendent.

Because Kalamazoo is able to raise sufficient funds from its local property taxes, it is considered "out of formula," and therefore does not receive basic state aid. This reduces the district's risk during times of state cutbacks. (The district remains eligible for categorical education funds.)

Kalamazoo has a number of blacks in elective offices, including one member of the seven-person school board, a city commissioner, a county commissioner, and two community college trustees. The city manager is also black, and the city currently has its first woman mayor. An open housing policy characterizes the city; blacks with sufficient resources can live wherever they choose, although about half the black population lives in one area.

In 1982 there were 202 births to women under 20 living in the city of Kalamazoo. Of these, 56 percent were to white and 43 percent to black teenagers. In Kalamazoo County, there has been a steady and constant decline for 12 years in the number of births to white teenagers (15 through 19); white teen births declined by 52 percent. (See Tables 5-1 and 5-2). The numbers of births to girls under 15 are too small for reliable analysis. Black teen births in the County, however (nearly all of which are to city residents), have remained nearly stable, numbering just about 100 each year.

Current Services for Pregnant and Parenting Adolescents

CEYF. The Kalamazoo School District has provided a comprehensive program for pregnant and parenting students since 1968. Housed in a former high school building, as it has been since 1972, the Continuing Education for Young Families (CEYF) program incorporates a five-room child care facility on the first floor, as well as much of an upper floor devoted to classrooms and office space. The program accepts students betwen the ages of 12 and 19 who are in grades five through 12. Students need not, and usually do not, leave the program soon after delivery. There is a greater emphasis on encouraging students to graduate from CEYF than on their returning to a regular high school. The child care program includes special staff and space so that a new mother may spend part of the day with her infant.

Beginning when her baby is about two weeks old, the young mother and her newborn spend most of the day together in the "Newborn Room," where teachers work with the pairs. The teachers foster the bonding process while they simultaneously model and teach appropriate methods of child care. At the same time, academic instruction is carried on in an individualized way, with content related to the experience of being a mother.

Over the course of the 1982-83 school year, the program served a total of 179 mothers and 124 children. About half the mothers dropped out during the year, so that as of May 1, 1983, there were 92 mothers and 68 children enrolled. (The day care center also serves children whose mothers are attending other school programs.) Kalamazoo's program has received state "model site" funds for three out of the past four years.

Table 5-1

Live Births by Age of Mother, by Race

City of Kalamazoo

1980 and 1982

	1980			1982		
	All Ages	Under 15	15-19	All Ages	Under 15	15-19
Total live births	1369	8	194	1427	5	246
White	1030	1	113	1061	2	151
Black	310	7	80	343	3	93
All Others	29	-	1	23	-	2
Percent of total births that were to teens	14.7%			17.6%		

Source of Date: Michigan Department of Public Health, Office of Vital and Health Statistics

Table 5-2

Live Births by Age of Mother, by Race

Kalamazoo County (including Kalamazoo City)

1970 - 1982

Year	1982			1980			1978			1970		
	All Ages	Under 15	15-19	All Ages	Under 15	15-19	All Ages	Under 15	15-19	All Ages	Under 15	15-19
Total live births	3110	10	321	3245	5	389	2916	5	403	3630	6	584
White	2684	3	234	2796	2	290	2552	3	304	3335	2	494
Black	374	7	85	408	3	97	336	2	94	280	4	89
All Other	52	-	2	41	-	2	28	-	5	15	-	1
Percent of total births that were to teens		10.6%			12.1%			14.0%			16.0%	

Source of Data: Michigan Department of Public Health, Office of Vital and Health Statistics.

The program's staff has had remarkably little turnover. Only two directors have been lost, one due to death and the other to retirement; the current director has held that position since 1978. A nurse, a social worker, and a teacher have all been on the staff for more than ten years. Over the years CEYF has experimented with a variety of service modes, including satellite and home day care programs, life skills education, grandmothers' meetings, and group counseling, among others. Some of the experimental efforts have been successful, and have become permanent parts of the program, while others have fallen by the wayside either because they were deemed unsuccessful, because they were unmanageable, or because funds were unavailable to support them.

Social services are provided through a cooperative arrangement with the Family and Children's Service agency. That is, the workers are employed by the agency and assigned to CEYF. The program has had as many as eight social workers in past years, but was reduced to two workers by 1982-83. One of these is supported by Title XX funds, while the other is paid out of state "model site" funds. The CEYF nurse, who began as a volunteer in 1970, works closely with the two local hospitals, both of which are private.

Beginning in 1982, Bronson Hospital has had a teen clinic on Wednesday evening, serving about 30 girls per session. (Wednesday was chosen because it is "late shopping night," and the buses run late.) The clinic has a non-rotating staff of physicians as well as social workers, a dietician, pediatric and obstetric nurses, and a prenatal educator. The CEYF also attends. The clinic provides the major source of referrals to the program.

A girl who opts to continue at her regular high school rather than coming to CEFY may attend Bronson Hospital's adolescent prenatal clinic. While these services do not include an educational component, and therefore are not comprehensive, they do incorporate some counseling and referrals for further help as needed.

Burgess Hospital, a Catholic institution, has both a maternity home and an obstetrical clinic, the latter serving women of all ages. The residents in the home tend to be above school age, because the facility offers a work program through which the young women can support themselves. Their employment income makes it difficult for them to qualify for AFDC or Medicaid. The city busses maternity home residents who have not yet finished school to CEYF. They

usually number about four each year. There is some concern on the part of the Catholic Family Service staff, which supervises the maternity home, that at CEYF a girl who is considering adoption is subject to peer pressure to keep her baby.

Service Climate

Kalamazoo prides itself on being a good place to live. Virtually every professional contacted in the course of this study spoke glowingly of the quantity and quality of services available in the city. One used the word "astonishing," noted the local "penchant for integrating services," and concluded by saying, "If I had to be poor somewhere, I'd like to be poor in Kalamazoo." Other respondents noted the importance of the religious (especially Dutch Reform) ethos, and of the leadership role taken by wealthy local families in making sure that people who need help get it.

Since its earliest days the CEYF program has taken advantage of the supportive environment, in part by developing an active advisory board. The board has representation from a large number of agencies that refer to CEYF, serve the same clientele, or have an advocacy interest in the population. Close linkages with other local providers have served the program well over the years, protecting it from more drastic cuts and possibly from the loss of its director. In 1981, the program drew up a "Joint Statement of Concern" which stated that "In the overall scheme of priorities, we the undersigned, concur that state support for interagency comprehensive programs for pregnant adolescents and school-age parents is one of the highest." The statement was signed by directors of 30 organizations, including both the Right-To-Life Association and Reproductive Health Care, a family planning and abortion facility.

Historical Development of Services

In 1966, a teacher of the homebound began to teach pregnant students as a group in a classroom at the local business school. Title I (ESEA) funds were used to pay the business school. In its second and third years, the program was located in a church. By the fall of 1968, CEYF had a staff that included seven classroom teachers, a head teacher, a counselor, and a half-time social worker. During the 1968-69 academic year the program served 104 pregnant students. CEYF moved to larger quarters in a more centrally

located church in 1969, and began a day care program in the 1969-70 school year. In this early period, funds came from Special Education and Title I, the Intermediate School District (made up of several local districts, and somewhat analagous to a county district in other states), March of Dimes, sending school districts and Civic Fund, a local foundation. The district's Supervisor of Special Education at the time was heavily involved in the issue of school-age parenting on the state and national levels.

In 1971, CEYF began to receive teacher reimbursement funds from the state under Public Act 242. Between 1966 and 1972, the program was housed in several city churches. In 1972, it moved to the former Central High School building, where it has been ever since.

In 1975, when Dr. Porter spoke at the Denver NACSAP conference, the CEYF director followed up by inviting him to inspect the Kalamazoo program. He did so, and local leaders recall that he said he hoped to see developed a state-wide program based on the Kalamazoo model. The director of the Kalamazoo program served on Porter's initial Task, and played a major role in drafting the "model." Kalamazoo was one of three "model sites" funded in the first year of the new state program (1979-80).

Between 1975 and 1980, CEYF ran a very large child care operation, with enrollment as high as 450 in one year, ranging in age from newborns to five year-olds. Children were served in the center, in satellites and in a home (outreach) program, in which instructors made home visits to teach mothers to care for their children. Eventually, these services were found to be too expensive and they were scaled back. The program's third and current director took over in 1978. (The second director subsequently became the founding president of NOAPP, the National Organization of Adolescent Pregnancy and Parenting.) The current director had previously handled public relations for the Kalamazoo School District. Like her predecessor, she had not previously had any particular interest in pregnant students. She, too, has devoted much effort to cultivating community support and working with providers from other communities.

Before 1981, when the program experienced cutbacks due to both Michigan's financial crisis and reductions in federal aid, the CEYF nurse and social worker provided services through the summer months. They saw prospective students and followed those who were already enrolled. The funding cuts necessitated that they begin to refer to other social

service and health agencies for care during the summer. The close linkages the program has always had with community agencies facilitate the functioning of this new arrangement. School and day care services have only very rarely existed during summer vacation. The program found that young mothers did not want to go to school during the summer.

Factors Enabling and Hindering Service Development

Resources. One of the most significant resources available to the CEYF program is the close and cordial working relationship that exists among service providers in the city. The linkage between the Family and Children's Service and CEYF, through which the latter has always provided social work services, is one manifestation of the relationship. Another is the fact that 30 agency heads would sign a statement of support for CEYF in 1981 when its future looked uncertain. A third is the fact that at various times when the school board has threatened to close the program, it has been deluged with letters of support for it.

The Continuing Education program has also benefited from the availability of financial resources in Kalamazoo. Recently, for example, the Kalamazoo Foundation has "bailed the program out" by contributing $70,000 each year. This has helped compensate for the loss of state and federal funds. United Way money has been used to match Title XX dollars and the local March of Dimes has made contributions from CEYF's early days. In addition, not only did two churches make space available to the program, but church women's groups regularly provide in-kind contributions such as handmade blankets to CEYF.

CEYF has benefited also from high quality leadership. The founding director and the supervisor of Special Education provided dedicated guidance in the program's early days, at a time when services to pregnant students were often stigmatized. Their achievements reflect the caliber of leadership available in Kalamazoo. They also gave a major boost to the program during its vulnerable initial stage. The second and third directors helped to get the program institutionalized and well connected to the networks of providers on the local, state, and national levels. They have conducted what amounts to a discrete but thorough public relations campaign over the course of the years.

The upper levels of the school administration do not appear to have had so direct an impact on the program as

administrators have had in other study cities. The frequent shifts in superintendents may be one reason. The fact that since the late 1970s CEYF has had the status of a school, and its director the status of a principal, must be counted as another reason that the program needs somewhat less "protection" than other programs do. The administration does, however, bear responsibility for choosing CEYF's principals, and those choices have certainly had great consequences. When the founding director died, her successor was appointed at a critical time, when the issue of school-age pregnancy was first becoming visible and salient. State funds had just been appropriated to reimburse the program's teachers. This woman was an energetic lobbyist and coalition-builder. She developed an organization with solid local support, capitalizing and extending on her predecessor's efforts. Her work at the state level also benefited the Kalamazoo program, by spreading its reputation, by establishing it as a "model" to be emulated, and by giving local leadership a voice in state policymaking. The third director's background in public relations has served CEYF well over the years she has directed it. She knows what will "play well" in the community, and takes advantage of the program's potential appeal.

The skill that CEYF's leadership has demonstrated in lobbying on behalf of the program is evident in their sensitivity to community reaction. For example, the current and former directors point out that as much as possible, and especially when photographs of the program appear in the local paper, they like to emphasize their services to babies. They have found that "there's something about a baby that will turn the tide every time."

State-level attention, personnel, and funds must also be counted as important resources for CEYF. Although state technical assistance and monitoring have been minimal, there has always been a core of administrators, at least one in each relevant agency, with some sensitivity to the needs of pregnant students. The legitimacy which state concern has bestowed on local programs must not be overlooked or underestimated as a "resource." State money has also been critical, especially to Kalamazoo, which began to receive "model" support at the very time other sources of funds were evaporating.

Another resource of Kalamazoo as a community is its capacity for planning and organizing to meet local needs. This capacity is evident in several recent reports that have been prepared by citizens' groups. Particularly interesting

was Kalamazoo 2000, "an organization of citizen committees for the purpose of developing coordinated, long-range plans for Kalamazoo County..."[14]

Kalamazoo's relative affluence and its relative independence from the vagaries of the automobile industry are also significant resources (especially in the 1980s, when that industry is in decline). Kalamazoo is one of the few large cities in Michigan in which many jobs are provided by locally-based corporations which have a stake in the community's viability, rather than by branch or subsidiary plants of the major car manufacturers. The Upjohn Company is the most notable Kalamazoo-based concern.

Constraints. Kalamazoo also faces constraints, some similar to those in many cities, and others unique. One of the common limitations Kalamazoo providers face is community attitudes. Although the specific expression of those attitudes may differ from one part of the country to another, the impact is similar. One CEYF staff member, for example, believes that the opinions of "the man on the street" in her community are that "you are promoting pregnancy," or that "our tax dollars are being wasted on this program." Pregnant teenagers are not "a popular cause politically," the administrators acknowledge. These beliefs lead directors and staff to keep a low profile, which reduces community awareness of both problems and services.

While Kalamazoo is relatively more affluent, and has relatively better access to financial resources than many other cities in Michigan, the state's fiscal crisis does impinge on the city. Level funding of the teacher reimbursement formula program has required the school district to contribute more than half the teachers' salaries for the program. This situation cannot strengthen CEYF's local position.

Several providers in Kalamazoo expressed concern about the fact that the proportion of black students at CEYF had increased over the years, so that as of May 1983, it stood at 60 percent. This current proportion of blacks in the program somewhat exceeds the proportion (43 percent) of teen births to blacks in the community. The increasing ratio of blacks in the program does, however, reflect a real increase in the relative numbers of black and white teen births, which was discussed earlier. It is not yet clear whether the increasing percentage of minority clientele will affect CEYF's ability to attract financial support.

One aspect of the Kalamazoo program which merits further comment, and may constitute a constraint on service development, is CEYF's structure and orientation. Much has been written about the relative advantages and disadvantages of the self-contained or "inclusive" model of service provision to pregnant and parenting students, which CEYF exemplifies. Zellman among others argues that the inclusive model, because it is expensive and is not appropriate for all students, should not be a school system's only means of dealing with this population.[15] Kalamazoo's CEYF makes a greater effort than most such programs to encourage students to stay in school after delivery, allowing them to continue coming to the alternative school, and to graduate from it. Yet, even it has a high drop-out rate. The program receives most of its referrals not from other schools but from the clinic at Bronson Hospital, an indication that linkages with social and health service agencies may be stronger than linkages within the school system itself. CEYF currently does no outreach to junior or senior high schools, either to locate referrals or to follow up on past enrollees. The fact that it is the only school-based service offered to pregnant and parenting students points to a possible desire on the part of the district's administration to keep pregnant students in one place and to limit attention and resources devoted to them.

Conclusions

Kalamazoo's Continuing Education for Young Families program provides a range of services that qualifies it, under our definition, as a comprehensive program. As funds have waxed and waned over the years, it has added and withdrawn components, such as job training, life skills education, and the satellite day care arrangement. It has a stable and dedicated staff, members of which have worked with state and national coalitions for the past 15 years. Located in a former high school building, it has plentiful space and good facilities.

The extensive day care services the program offers is an inducement to enrollees, and a way of helping students finish school. The program permits students not only to stay through the semester of delivery (which many "inclusive" programs do not), but also permits continuation until graduation. The effort the program makes to work with mother and newborn together during the early weeks, and to allow new mothers to study in the room where their babies are napping, is exemplary.

While CEYF has good documentation of its history as a program, it has done little by way of evaluation of its services or follow-up of students after drop-out or graduation. This is certainly disappointing to the researcher, but hardly surprising. The directors' lobbying efforts--far more extensive and successful than most--do not seem to have been hampered by their inability to document results.

But, CEYF is expensive. Its income did not cover its costs in 1982-83, even with help from the Kalamazoo Foundation. How long the school district will continue to support the program at its present level cannot be certain. If the state's "model site" funding should be withdrawn and/or redistributed to other districts, CEYF might face substantial cuts.

The origin and subsequent development of Kalamazoo's CEYF fits a familiar pattern. Started by a homebound teacher, it then gained local support in the philanthropic community. The local support was enhanced by the program's exemplary status and the broader reputation it came to enjoy.

Characteristic of the more comprehensive programs, it has drawn upon a wide range of funding sources over the years. The existence of relatively stable state funding and the flexible, local foundation and United Way support has enabled it to weather the periodic cutbacks and bridge some of the service gaps.

Like the other more comprehensive sites, service coordination has been facilitated by a long tradition of community planning, low turnover of agency leadership, and a strong United Way planning organization.

It is significant that even in this progressive community, program advocates have felt the need to be cautious in promoting the services. Some fear opposition from those in the schools and community who believe that the programs themselves induce adolescent pregnancy. The maintenance of a separate, self-contained school program is consistent with a low-profile posture.

III. SAGINAW

Saginaw is Michigan's most northerly large city. The Saginaw River, which was the scene of major lumber operations in the 19th century, originally separated two muncipalities, Saginaw (chartered in 1857) and East Saginaw (incorporated in 1859). Although the two were consolidated by the state legislature in 1889, tension continues to characterize the relationship between the city's east and west sides. Saginaw has 77,000 people and is the dominant city in an SMSA of 228,000. The city has a large minority population: 35.5 percent of its citizens are black, and nearly 6 percent are Hispanic.

The 1980 U.S. Census revealed that the proportion of Saginaw's employed workers in manufacturing industries was nearly identical to the proportion of manufacturing employees in the state--31.4 percent for Saginaw, 30.3 percent for the state. But, while 21.4 percent of all workers in the state were in "managerial and professional specialty occupations," only 15.4 percent of Saginaw's workers fell into that classification. Moreover, even in 1979, when the state unemployment rate was at 11.0 percent and was just beginning to climb, Saginaw's rate was at 19.0 percent. Finally, Saginaw's population is significantly more poorly educated than that of the entire state: while 68.0 percent of all persons aged 25 and over in Michigan are high school graduates, only 57.6 percent of Saginaw residents are, and while 14.3 percent of the state's residents (25 and over) have completed four or more years of college, this is true for only 8.4 percent of Saginaw's population.

The city's economic base, its population, and its school enrollment have all been shrinking in recent years. The city has seen the closing of some of its largest plants, a major General Motors factory and a Wickes Corporation plant. Wickes, a conglomerate which began with the lumber industry in Michigan, moved its corporate headquarters from Saginaw to San Diego in 1972; few other large companies are based locally. One author suggests that the city's limited pool of well-educated workers played a role in causing Wickes to transfer its headquarters out of Saginaw.[16] The city's population declined by 15.6 percent between 1970 and 1980, causing corresponding reductions in school enrollments. The situation has stabilized over the past few years, although the "white flight" of the previous decade has created a school

population that is nearly two-thirds minority (over 50 percent black, 12 percent Hispanic, and about 2 percent Asian).

Saginaw's Board of Education and City Council are elected at large, rather than by districts. The School Board has one black member out of seven, while two out of nine City Council members are black. The city's Superintendent of Schools has been in that position since 1978, having worked as a teacher, principal, and assistant superintendent in the system over the course of nearly 20 years. During his tenure as superintendent, he has put the district on more secure financial footing. He has developed a "step by step management system" emphasizing zero-base budgeting and district-wide needs assessments. "White flight" has been halted, and some middle-class families are being attracted back to the city by the district's specialized programs.

In 1982, there were 349 births to women under 20 in Saginaw. This constituted 22.3 percent of all births. Sixty-one percent of all teen births (212) were to blacks, whereas only 47 percent of births to women of all ages were to blacks. Over 90 percent of all births to black teens in Saginaw County, but only 65 percent of all teen births, were to residents of the city.

Current Services for Pregnant and Parenting Teens

Pregnant and parenting students in Saginaw who are at least 16 or in the ninth grade may enroll at the Adult High School at the Ruben Daniels Lifelong Learning Center, a public school which also incorporates the district's "gifted and talented" programs. In addition, the Center contains a day care center for 20 children. Although it is called the "Program for Young Parents," what exists may only loosely be defined as a "program." There is no separate space allocated for pregnant students, and the only staff member of the "program" simultaneously serves as the Health Services and Health Education Coordinator for the entire district. This woman, a nurse, also teaches childbirth education classes, enrolls pregnant students, and is responsible for monitoring their progress. Approximately 168 pregnant students were enrolled at the Lifelong Learning Center during 1982-83; 102 of these were under the age of 18. Any student who is neither 16 nor in the ninth grade stays at her home school and may come to the Center on Fridays for childbirth education and other relevant course work. Lunch, snacks, and transportation are available to pregnant students at no cost.

The Lifelong Learning Center does not have a social worker on its staff. There are school social workers for the district but they serve only families of children in special education programs. Child and Family Service of Saginaw County provides the Program for Young Parents with a worker for one hour each week, and additional volunteer time is being sought. The nurse/coordinator of the Program for Young Parents makes referrals to private physicians or hospital clinics and, when she considers it necessary, to the Public Health Department for visiting nurse services.

The Saginaw school district's Program for Young Parents has been offered within the structure of the Ruben Daniels Lifelong Learning Center since 1981, when the Center opened. The program consists more of an enrollment and monitoring system for pregnant students who take regular adult education classes than a system of providing comprehensive care. Pregnant students do not have their own space; only one part-time staff member provides special services and teaches special classes (of which each student is enrolled in one per semester). The Center houses a day care facility but no special services other than parenting education are offered for students after delivery.

As noted above, statistics from the Michigan Department of Public Health indicated that there were 349 births to women under 20 in Saginaw in 1982, 60 percent of them to blacks. If approximately half or 84 of the pregnant students enrolled at the Daniels Center in 1982-83 were white and half were black, as was reported informally, then proportionately, the community's white teenagers were considerably better served than its black teens. This contrasts with the situation that had existed previously (discussed in more detail below), when the district supported a comprehensive Continuation School with an enrollment of 163 students, 133 of whom were black.

Saginaw's system of "mainstreaming" pregnant and parenting students in an adult education program that is not tailored to their needs is subject to varying interpretations and evaluations. On the one hand, the Lifelong Learning Center is a school setting which will be available to students for the rest of their lives, not just during pregnancy or for a limited time thereafter. The building also offers a somewhat wider variety of course options than do many self-contained programs. On the other hand, little effort seems to be made to help pregnant students who might want to return to their former schools after delivery, and no services are available to students who are eligible for adult education (that is, aged 16

or in the ninth grade), but who choose to remain in their home schools.

The County Health Department has operated a Maternity and Infant Care (MIC) program at Saginaw General Hospital since 1975. About 350 patients per year are delivered under the MIC program which provides social work and nutrition counseling, as well as medical care. The average age of MIC patients is 21, and 35 percent of all patients are 18 or under. Of the 120 adolescents the MIC program sees each year, about 60 to 65 percent are black, while only 30 percent of all patients are black (55 percent are white, and 15 percent are Hispanic). The social worker at the MIC program is President of the Advisory Board for the Program for Young Parents.

Service Climate

Saginaw is physically divided by its river, but the division is more than a geographic one. The west side of town is the "white" side, while most blacks and Hispanics live on the east side. Only a narrow strip downtown is "neutral turf," and any agency hoping to serve all segments of the community must locate there. When the comprehensive program at the Continuation School was closed, and the program reorganized and moved from an east side church to the new Lifelong Learning Center in 1981-82, there was a striking increase in the number of white students served, as mentioned above. Of the 163 students served in 1980-81, only 15 had been non-minority while 133 were black and 15 were Hispanic. Accurate counts by race for 1982-83 were unavailable, but it was estimated that the proportion was similar to the 50-50 ratio of all adult education students.

Many issues relevant to the nature of the service climate were raised when the school district closed the former Continuation School and opened the Program for Young Parents at the Ruben Daniels Center. Several members resigned from the program's Advisory Board, and the hostilities were still evident two years later when interviews for this study were conducted. Current Board members had very different memories of how many had resigned and who they were. (See Historical Development section below.)

Neither the United Way nor any other agency in the city has engaged in comprehensive planning efforts in recent years. On a more limited scale, several programs in the county for runaway youth have coordinated their efforts, as

have a number of churches which are trying to develop an "Emergency Needs Network" (EmerNet). These efforts do not directly affect many pregnant or parenting adolescents, however.

No local foundation seems to have played a role in supporting services for pregnant adolescents. One of the largest foundations based in Saginaw, the Harvey Randall Wickes Foundation, prefers to provide funds for "bricks and mortar" rather than operating expenses. It has supported educational institutions, as well as hospitals and community centers in the area.[17]

Historical Development of Services

Saginaw had one of Michigan's earliest comprehensive programs serving pregnant school-age girls. The Continuation School was begun in 1966 as the result of a study of dropouts initiated by a group of guidance counselors and others. It was housed in a series of east side churches until 1981. Funding came from federal sources, especially Title I of ESEA, and Title IVA of the Social Security Act, until 1978 when the local school district took over financial responsibility. Beginning in 1971, the program also received state teacher reimbursement funds. It did not receive state "model site" funds, although one of its directors participated in the state-level School Age Parent Task Force.

The Continuation School's first director (from 1966 to 1970) was a counselor; the second director (from 1971 to 1977) was a teacher, who has since become an assistant principal; and the third director (between 1977 and the consolidation into the Ruben Daniels Center in 1981) was a social worker. By the late 1970s, the program employed a staff of five certified teachers, a part-time nurse, a secretary, and the director, who also counseled students. It offered educational, health, and social services to its students, as well as door-to-door transportation, but never provided day care or follow-up after delivery.

During the late 1970s, several events took place which had important consequences for the Continuation School: in 1977, the school's last director took over; in 1978, the local school district assumed responsibility for funding the program, the school moved to its third church, and the current superintendent was appointed. By late 1978, planning for the new Lifelong Learning Center was under way. The school district ultimately purchased a former Montgomery Ward store

whose location was central enough that students from both sides of the river would attend. Spacious and modern, the building is well suited to many of its new uses. It was purchased and renovated at a reasonable cost, and represented a creative solution to several problems--most importantly, a desire to provide extra programs for the "gifted and talented," and thereby halt the flight of middle-class families from the system. The Center was to house a somewhat unusual assortment--adult education, adult basic education (i.e., literacy program), "gifted and talented" and pregnant students. The gifted and talented program provides "enrichment" for approximately 350 students in grades seven through 12 who attend their regular schools for a half day and the Center for the other half. Nearly one-third of the building is set aside for their exclusive use.

Members of the Continuation School's Advisory Board recalled that they "saw the handwriting on the wall" in terms of the school's future when blueprints for the Lifelong Learning Center showed no space set aside for the pregnant students' program. Nevertheless, in June 1981 the director of the Continuation School was told that she and two of her six staff members would move to the Ruben Daniels Center in the fall to run the program there. The administration argued that a smaller staff would be necessary, since some services would be available within the new Center. Just before school opened in September, however, the director learned that she would no longer be administering the program; instead, she would return to being a social worker with the special needs population. Rather than actually moving to a new location, the Continuation School program was to be restructured and transformed.

In its new setting, the program would serve only students who were at least 16 or in the ninth grade, whereas the old Continuation School has served younger girls as well. There would be neither separate staff nor separate classes. Rather than door-to-door transportation, students would receive free passes to public transportation. There would, however, be a day care facility, one large room devoted to child care, with priority given to pregnant students and parents at the Center. These changes meant that both students and staff had to adjust their plans at the last minute.

The role of the Continuation School's Advisory Board throughout these events merits discussion. At the beginning of the 1980-81 school year, the Advisory Board appointed a Curriculum Committee and charged it with the task of

studying the existing curriculum and making recommendations for changes. The Committee administered questionnaires to all current students and to 14 former students (all in the 11th grade at one high school). They also met with the school's teachers to learn about the curriculum from them. The student questionnaire provided the bulk of the "data" for the Committee's written report, but the questionnaire itself was poorly designed, and only had about a 25 percent response rate (42 responses out of 163 students). Although the Committee's "findings" are therefore open to question, their general import is of some consequence. Students were asked to rate the help they were receiving from the school on a scale ranging from very good to very poor. Students were by no means extravagant in their praise of the program. For example, there were only two questions on which over 30 students give the program the highest possible rating: 32 said the program was "very good" at helping them to accept their pregnancies, and 38 indicated that the course work would help them "keep up when (they) returned to (their) home school(s)." On a series of questions about how much the school was helping in specific content areas, there were many "very goods," but also many "goods," and a noticeable number of "fair," "poor," and "very poor" responses. Analysis of the Board's role is continued in the next section.

Factors Enabling and Hindering Service Development

Resources. The fact that Saginaw had one of the earliest programs for school-age mothers may be counted among its latter-day resources. The city's long history of activity and even leadership in the state probably meant that the program had a local constituency, so that it could not be completely dismantled. As noted above, a director did work on the state-level Task Force. The funding and legitimacy the state Department of Education bestowed on the Continuation School were also important resources. Saginaw also had several churches that were willing to house the program, although for a rental fee.

Constraints. The factors constraining development of services to pregnant teens in Saginaw are numerous. They include elements of the program itself, as well as elements external to the program and even to the school system. Factors external to the schools include the city's difficult and deteriorating economic picture and the accompanying "white flight." One result of this situation is a desire on the part of both politicians and administrators not to emphasize programs that serve a primarily low income, minority

clientele. There is a corresponding wish to promote those services that are geared to populations with higher incomes and higher social status (such as education for the gifted).

Further constraining service development is the absence of strong organization within both the minority community and the social service sector. Viable coalitions within or among those groups are not evident.

From within the school system it is possible though not certain that the Continuation School was weakened as a result of administrative techniques adopted by the present superintendent. His reliance on "zero-based budgeting" means that, as the district's pamphlet "Saginaw Schools: A Step By Step Management System" says, "Each item (is required) to be justified annually." As part of his management system, the superintendent also uses frequent "needs assessments." The system's pamphlet defines the purpose of needs assessments in these words:

> "(They) can help to determine priority needs, allocate scarce resources, increase staff and community involvement--and increase accountability."[18]

The document emphasizes the scientific nature of needs assessments and the accountability which zero-based budgeting develops. However, these techniques may tend to favor general rather than special programs.

For example, in the 1980-81 school year, the district's Department of Evaluation, Testing and Research conducted a "District-Wide Comprehensive Needs Assessment Study," based on questionnaires completed by samples of parents and students, and by all teachers and administrators. That study pointed to the following functions, in the order given, as "the highest need areas": 1) Personnel; 2) Staff development; 3) Auxiliary services and support staff; 4) Communications/Public Relations; 5) Personal Development of the Student; and 6) Educational Programs--Elementary.[19] This list suggests that any function that is not system-wide may not garner many "votes."

A final constraint is the absence of lobbying and coalition-building that has helped sustain programs elsewhere. The Advisory Board, comprised of about 15 social service professionals, was apparently unaware of the school's precarious situation, and unable to protect it. The

superintendent's office never notified them or their president that the Continuation School would not be opening in the fall of 1981. Board members learned about the closing through the local newspaper. When they tried to present their case to the School Board, they were unable to get a place on the agenda.

Conclusions

A once bustling manufacturing center, Saginaw is now a city in decline. "White flight" and plant closings have left a city with a shrinking tax base and large minority and unemployed populations. The river that once separated two municipalities still divides the city. It is commonly reported that whites live on one side of the river and minorities on the other, with only a small meeting ground in the center.

Saginaw had one of Michigan's (and the nation's) earliest programs serving pregnant teenagers but in essence abolished it in 1981. A non-comprehensive program replaced it, housed in the city's new Lifelong Learning Center. Only students who are 16 or in the ninth grade may attend the school, and they receive minimal health-related services and virtually no social work services. Junior high school students must remain at their regular schools, but may be bussed in to the Daniels Center for a few hours of special classes one day each week. The new Center serves more white students than did the Continuation School and operates a day care facility with 20 places, which gives priority to students who attended the school while pregnant.

Pregnant and parenting students are thus mainstreamed into an adult learning system. They have a fairly wide variety of course options and receive some special services. On the negative side, mainstreaming this vulnerable population with adult education students (many of whom have dropped out of or been expelled from regular school) falls short of the ideal. Moreover, mainstreaming in this case actually means that the pregnant students may attend the adult education center just as other students do with no special space or separation and with barely any sense that someone is advocating for them.

As the experience of Saginaw demonstrates, state funding is in itself insufficient to maintain comprehensive services in the absence of other essential local resources. Saginaw, a relatively poor city, lacks the community planning traditions and mechanisms as well as the local philanthropic

support that has been so important to Kalamazoo and the other more comprehensive program sites.

Like virtually all the other programs studied, Saginaw's program was initiated by local female service providers. However, unlike the more successful programs, it failed to attract sufficient support from the predominately male administrators and funders and policymakers that might have enabled it to continue on a more secure footing.

NOTES

1. U.S. News and World Report, February 28, 1983.

2. Bailas Walker, Jr. The Impact of Unemployment on the Health of Mothers and Children in Michigan, Recommendations for the Nation. January 1983, Hearing Committee on Education and Labor, Sub-committee on Labor Standards, Washington, D.C. (Unpublished), p. 9.

3. Ibid, pp. 10-11.

4. Administrative Code Rules Governing Educational Program for Pregnant Adolescents and School Age Parents, p. 2.

5. An Informational Report on Pilot School Age Parent Projects, Model Sites. Michigan Department of Education, School Program Services, August 1982, p. 8.

6. Ibid, p. 9.

7. Public Act 226 of 1977.

8. The Family Planner, Winter 1980, 10(1), p. 1.

9. Sex Education Guidelines, Including Reproductive Health and Family Planning. Michigan Department of Education, July 1978.

10. Ibid.

11. Jeanette Valentine. Background Paper Series for the Statewide Task Force on Pregnant and Parenting Youth of School Age in Massachusetts. Background Paper 3: A Review of Three Statewide Comprehensive Educational Programs for School Age Mothers: California, Michigan, Delaware. September 1983, Unpublished Report, p. 18.

12. An Informational Report..., p. 11.

13. Kalamazoo 2000 Summary Report, February 1983, pp. 3-4.

14. Ibid, pp. 1-2.

15. Gail L. Zellman. The Response of the Schools to Teenage Pregnancy and Parenthood. R-2759-NIE. Santa Monica, CA: The Rand Corp., 1981, pp. 16-49.

16. George Bush. The Wide World of Wickes. N.Y: McGraw-Hill, 1976, p. 360: GM's Saginaw Steering Gear, as the area's biggest employer, almost pre-empted the skilled clerical labor pool.

17. Ibid, p. 421.

18. Saginaw Schools: A Step by Step Management System. School District of the City of Saginaw, Michigan, p. 10.

19. Ibid, p. 9.

Chapter 6. Tennessee

I. STATE POLICIES AND PROGRAMS

Tennesee's location in the region which H. L. Mencken dubbed the "Bible Belt" has engendered traditions and concerns different in many respects from those of the other states included in this study. The state consists of three "grand divisions," which are referred to in its constitution. These three areas are distinct geographically, economically, and politically. The mountains of the East give way to a plateau mid-state, and then to lowlands adjacent to the Mississippi River. East Tennessee encompasses the Appalachian region as well as the large cities of Knoxville and Chattanooga. Its people are poor and isolated; tobacco is a major crop. It has been a Republican stronghold since the time of the Civil War. Both Senator Howard Baker and the current Governor, Lamar Alexander, are Republicans from East Tennessee.

Middle Tennessee, which includes the capital city of Nashville, contains one of the best agricultural areas of the state. Much livestock is raised there, and the area is especially known for its horses. Nashville itself houses many colleges and universities, and is also a major publishing and health care center.

West Tennessee, lower and flatter than the rest of the state, is dominated by Memphis, the state's largest city. Located on the Mississippi River, Memphis has long been a major cotton trading center, as well as a principal center of hardwood manufacturing. The Middle and Western parts of the state have traditionally been staunchly democratic.

With a 1980 population of nearly 4.6 million, Tennessee ranked 17th among all states. Its 1979 median family income of $16,245 gave it a rank of 47th. Seventy-five percent of the state's population had family incomes under $25,000,[1] compared to only 64.6 percent of all United States families. Only 16 percent of Tennessee's population is black,[2] and very few are of Spanish or Native American ancestry. Thirteen percent of all families and 20 percent of children under 18 were below federally established poverty levels of 1979.[3] As of December 1981, Tennessee had nearly 174,000 recipients of Aid to Families with Dependent Children, of whom over

122,000 were children.[4] The average monthly payment per family was $112.93 (which is significantly lower than the average payments per recipient in the other study states). Tennessee has no state-funded general assistance program.

According to one elected official, Tennessee's Medicaid program is the smallest in the nation (save Arizona, which has had none). It was the last state to implement Medicaid (in late 1969) and offers very minimal coverage. The state also currently ranks 45th in the nation in per pupil education expenditures. An education initiative sponsored by Governor Alexander and recently passed by the state legislature provides additional funding for education, supported by an increase in the state sales tax. (There is no state income tax.) Rather than giving localities across-the-board increases in aid, however, the plan will provide "merit pay" increases for selected teachers.

Tennessee's legislature and revenues are notably different from those of the other study states. With a legislative session lasting only 90 days each year (because under the state's constitution, lawmakers can only receive per diem expenses for that length of time), and a salary of $8,300 a year, the job of a state legislator is very much part time. Indeed, the other study states pay their legislators, on average, approximately four times what Tennessee does, and sessions run through most of the year.[5] The state's (Fiscal 1980) general revenue of $3.5 million gave it a rank of 23 among the states, but 46 on a per capita basis.[6] The other three study states, with revenues ranging from two (Massachusetts) to eight (California) times those of Tennessee, are among the top 20 per capita. Tennessee's 1982 unemployment rate of 13.3 percent (up from 10.3 percent the previous year) was the fifth highest in the nation.[7]

Issues Related to Pregnant and Parenting Adolescents: Governor Alexander's Initiatives

Current interest in adolescent pregnancy in Tennessee is a corollary of concerns with "mental retardation prevention" and "healthy children." Governor Lamar Alexander, elected in 1978 and reelected in 1982, has made children a focus of his administration. In August of 1980, he formed a Task Force on Mental Retardation which was chaired by his wife, Honey Alexander.

The Task Force was begun out of a concern that Tennessee had an unusually high incidence of mental

retardation, particularly of neural tube defects (e.g., spina bifida), especially among the Appalachian population. Its mission was "to study prevention programs currently offered in Tennessee ...to recommend activities, priorities, and allocations of resources that could reduce the incidence of mental retardation."[8] Through its work it became clear that prevention of retardation required varied efforts in many areas. High on the list of goals stated in the Task Force report were reducing the "frequency of unwanted teenage pregnancies" and providing every pregnant woman with "good care before, during, and after delivery."[9]

Teenage pregnancy, as Mrs. Alexander notes, "is big in Tennessee; it's always been big... It's a dubious distinction."[10] She points out that Tennessee has traditionally had, and still has, two distinct "problem" populations in this regard, poor whites in Appalachia and inner-city blacks. Among both these groups, adolescent pregnancy has been routine and well accepted. What she did not emphasize, but what is apparent, is that these two populations have also been among those least likely to receive adequate prenatal care because of their poverty and/or their isolation. Thus the pregnancies and the babies carry a double burden of risk.

In 1974, the legislature established a High Risk Newborn Program, with the passage of TCA68-1-801/804. In 1977, further legislation expanded the program to include high risk obstetric patients. Funds were first appropriated in that year, after an advisory committee had established an allocations formula.[11] The total statewide allocation for fiscal 1984 was approximately $3.1 million.

A Republican in a poor state, Governor Alexander's approach has been not to request major infusions of new money but rather to readjust priorities within the system, to conduct media campaigns, and to look for a small amount of new funding for a limited purpose. New funding was requested and received beginning in fiscal 1983 to assure the availability of prenatal care in all 95 counties. Since July 1982, funding has been available for prenatal care statewide. (Note that most workers in county health departments are state employees.) About one-third of the counties were already offering prenatal care, while in some counties the willingness of private physicians to accept Medicaid patients reduces the need for county care. Coverage has recently been made available to first time pregnant women upon verification of pregnancy. Although no authorizing legislation was passed, new funds for prenatal care were included in the

state budget: $1.8 million for fiscal 1983, and $3.6 million for each of the following two fiscal years.

In July 1983, the Healthy Children Initiative was officially begun, an extension of the Mental Retardation Prevention Task Force. A more positive and global way of approaching many of the same problems, the new initiative was undertaken with the knowledge that in 1980 Tennessee had the 13th highest infant mortality rate in the nation, and that (as the initiative's materials note) more than one-fourth of all the state's pregnant women, and two-thirds of pregnant teens, were receiving inadequate prenatal care. The new initiative is somewhat broader in its effort to prevent general health problems, as well as developmental disabilities. The initiative has four areas of emphasis:

Personal health - to ensure that all children receive health care;

Healthy lifestyle - to ensure that adults and children learn how their daily habits affect their health;

Social environment - to ensure that children grow up in a nurturing environment with people who care; and

Physical environment - to ensure that families have safe water to drink and clean air to breathe.

The Healthy Children Initiative received its initial appropriation of funds in fiscal 1985, which began in July 1984. Two and a half million dollars was appropriated by the legislature, $2 million to the Department of Health and Environment, and $500,000 to other departments, including the Children's Services Commission and the Department of Mental Health and Mental Retardation. The Healthy Children Initiative is thus an interdepartmental effort. It has also involved the private sector. Private physicians have worked with local, regional, and state task forces which, in the words of one administrator, "multiplies what we can do at the state level." One outcome of this work has been that some physicians have agreed to provide free care for indigents.

Related Issues

Bound up ideologically and politically with the Healthy Children Initiative are several issues that also directly affect services to pregnant and parenting teenagers. These issues include abortion, adoption, and family life education.

Abortion. Abortion, which at the federal level and in many states is a politically polarizing issue, seems not to be so in Tennessee; there is apparently no serious political effort in support of abortion in the state. As one pro-choice advocate said (and as numerous other informants confirmed), abortion would be illegal in Tennessee were it not for the United States Supreme Court's 1973 Roe vs. Wade decision. We were also told that supporters of the pro-choice position make no effort to lobby legislators to support abortion because they consider the situation hopeless. While some legislators may not be adamantly opposed to abortion, no one will openly support it.

Abortion sentiment bears a direct relevance to Governor and Mrs. Alexander' work in "mental retardation prevention." One of the most clear-cut ways of "preventing retardation" is to screen for fetal anomalies by means of amniocentesis and to abort fetuses found to be defective. (This holds true, among other conditions, for spina bifida, a particular concern in East Tennessee.) Apparently because anti-abortion sentiment is so nearly unanimous in the state, abortion never, as Mrs. Alexander put it, "blossomed into a full-blown problem" for the Mental Retardation Prevention Task Force. Mrs. Alexander points out, as does the Task Force report, Tomorrow's Children, that the state funds five university-based genetic research and screening centers. She explains that a woman who is screened, and has amniocentesis resulting in knowledge that her baby will be born with a handicap, "may not choose to have an abortion." The information, however, can help her to be prepared to go through a grief process in advance and to look while she is still pregnant for the services that will be available for her baby.[12] This is a line of reasoning supported by many lobbyists for the handicapped.[13]

Adoption. Closely related to the abortion issue, particularly in the minds of some Tennessee political leaders, is adoption. This relationship is especially important to Senator Douglas Henry, a strong voice in the state legislature. Senator Henry, Chairman of the Ways and Means Committee, in the words of one state official, "is an extremely articulate advocate for children" and one who believes that "it is better for babies to be sold than killed." Senator Henry is involved on several fronts in trying to discourage abortion and increase the appeal of the adoption alternative to pregnant teens. Among his efforts are the following: an ad hoc (non-legislative) committee to stimulate the acceptance of a newly proposed family life education curriculum in the state's school districts, a statewide toll-free telephone number

that would provide information on local resources to any teenager "who is in trouble" (in the Senator's words) and changes in existing adoption laws.

This last effort is the most complex and the most potentially significant, although it is also the most uncertain. Stated simply, the goal is to create a mechanism whereby the resources of prospective adoptive couples would be used to support pregnant women who might otherwise abort. In other words, the adoptive couple would be charged a large fee, with that money being used to help support poor pregnant women. This would not be done in such a way that a particular adoptive couple was supporting a particular birth mother whose baby they would receive. (It is worthy of note that in Tennessee, although women with no other children become eligible for both AFDC and Medicaid on medical verification of a pregnancy, the benefit is so low, a maximum of $102 per month according to informants, that it brings recipients only to about half the poverty threshhold.) Because this technique would tip the economic balance in favor of carrying the pregnancy (since there is no state payment for abortions for poor women in Tennessee), it would presumably increase the pool of adoptable babies. In Senator Henry's words: "There's no point in parents who want to adopt babies being lined up from here to doomsday while girls are destroying babies because they have no money." Henry's plan involves having the Department of Human Services charge an application and home study fee of $200 to $500, and a placement fee of $5,000 to $6,000, similar to fees charged by some private agencies.

Professionals see a variety of flaws in Henry's ideas. They doubt that as a state agency they ever could or would charge the kind of fees he proposes. They would be much more likely to adopt a sliding scale fee system so as not to exclude the poor. The agency currently has a waiting list of approximately 750 prospective adoptive couples, and since the spring of 1982 has had a moratorium on accepting new applications. Professionals question the propriety of charging an essentially retroactive fee to couples on that waiting list, which causes them to ask how and when fees could appropriately be initiated. The program would also raise obvious problems regarding black and other "hard-to-place" (e.g., handicapped) children. Finally, while many private agencies condition subsidies to mothers on their ultimate relinquishment of their babies, it is questionable whether a public agency could legally do so.

Because Senator Henry is one of the Department of Human Services' strongest supporters in the legislature, his ideas are being listened to and taken seriously. Whether they will be implemented is another question. A new program that is being initiated within the Department reflects Senator Henry's interests, although it represents only a very partial step. The Parenting and Placement Program was begun in Knoxville in 1983, using federal "Jobs Bill" money, and is intended to be expanded throughout the state. The program provides both services related to adoption for mothers who might be interested in relinquishing their babies (the "placement" component) and counseling services for mothers who are keeping their babies (the "parenting" component). While the overriding goal of Parenting and Placement is to prevent child abuse--also an interest of Senator Henry, who successfully sponsored child abuse legislation--it offers the possibility of increasing adoptions, and of providing the locus for a fee-generating program.

Family Life Education

The third area that bears a relationship to adolescent pregnancy, and is of interest to Mrs. Alexander and Senator Henry, among others, is family life education. If this subject is a sensitive one in most states, in Tennessee it appears to be potentially explosive. Tomorrow's Children recommended that "public schools should offer family life education," while acknowledging that "this is an emotional issue to all parties."[14]

From October 1979 until late 1983, the state Department of Education orchestrated a major revision of its health education "guide." The new guide incorporates contents and objectives for nine subject areas and four grade levels extending from kindergarten through 12th grade. The most controversial area covered, Family Life Education, was also the last segment to be completed. Controversy surrounding it threatens to overwhelm all other aspects of the curriculum.

The next step following development of the curriculum guide is for it to be reviewed at the local level so that each school board (of which there are 147 in the state) can decide about its implementation. In this process, the Family Life Education piece is being handled separately--sent out in its own "plain brown paper wrapping," in the words of one respondent, and viewed as a "supplement" to the rest of the guide. There is apparent sensitivity among those who worked on the curriculum about the need for building supportive

coalitions throughout the state. Senator Henry is instrumental in this process. The committee which he has organized is working on Family Life Education, as well as other issues. The committee, it is often remarked upon, includes both conservative and liberal representatives, most notably supporters of both Volunteers For Life and Planned Parenthood. The membership of this committee--from both ends of the political spectrum--generally agrees on the importance of universal family life education. These people have, in fact, volunteered to provide in-service training for teachers, and to contact local school boards to encourage adoption of the new curriculum. Henry, himself, has also been meeting with district superintendents and school boards around the state with the same goal. The bringing together of people with so many different views is a major achievement on Henry's part.

Henry reportedly said to the committee that even if they could not all agree on what should happen once a teenager became pregnant, they could agree on the need for prevention and on the new Family Life Education curriculum as an appropriate step in that direction. As one informant put it, "No one is opposed to responsible parenthood and adolescent parenting is in most cases not responsible." In addition to establishing his special committee and lobbying directly with local decisionmakers, Senator Henry is also introducing a joint House and Senate resolution stating that health education, including family life education, should be required of all students for graduation. The Department of Education is not entirely comfortable with this prospect because, as one official explained, it is the Department's position that "the legislature has no business mandating curriculum."

Special Education Regulations

Until 1981, pregnant students were considered "handicapped," and school districts could collect additional state funds for serving them. While many districts provided homebound instruction as their only special service to pregnant students, some districts, including Nashville, Memphis, and Knox County, chose to provide special classes or schools for pregnant students.

In 1981, however, the state legislature revised its special education legislation, bringing it more closely in line with the 1975 federal Education for All Handicapped Children Act (PL 94-142). In order to maximize the federally reimbursed proportion of state expenditures, certain categories of

students who had been defined as handicapped by the state but not by the federal government were eliminated from the state definition. Originally, the groups to be written out included the "socially maladjusted," those with "learning problems," pregnant students and the gifted. Lobbying efforts on behalf of gifted students led to their continuing inclusion in the new legislation, but the other groups were ultimately omitted. (More accurately, cases of the "socially maladjusted" and those with "learning problems" tended to be recategorized as "emotionally disturbed" and "learning disabled" to conform with official, federal designations.)

This legislative change created an entirely new state of affairs for school districts vis a vis their pregnant students. Schools were no longer mandated to include pregnant students under their programs for the "handicapped," and would no longer receive special reimbursement for doing so. Neither were they required to offer any other special services for pregnant and parenting students.

The results of this change have not received much attention at the state level, so far as we could determine. This is at least in part because there is no lobbying effort in support of services for pregnant adolescents in Tennessee. The new legislation clearly did lead to a reduction in school-based services for pregnant youngsters, as was inevitable. For example, programs funded by state Special Education money were eliminated at least in Nashville, Memphis, and Knox County, and quite likely in other places as well. The obvious irony is that at the very same time that Governor Alexander was focusing major efforts on "preventing retardation," his bureaucracies were at work developing regulations that reduced services to an acknowledged high-risk population.

Conclusions

Tennessee is a poor and politically conservative state, with a long history of meager welfare assistance levels and minimal health services for the poor. Governor Alexander has initiated a number of efforts over the past several years which affect provision of services to adolescents who are pregnant and parenting. The most significant of these is the Healthy Children Initiative, which has increased availability of prenatal care services for the poor throughout the state.

At the same time, there is strong anti-abortion sentiment in the state, and a sense among some influential people that

reducing the number of teenage abortions would also achieve a second goal, that of increasing the number of adoptable babies. Efforts are thus underway to encourage adolescents to relinquish their babies, rather than having abortions or keeping their infants.

There is no one advocating at the state level on behalf of pregnant or parenting adolescents, and much cause for believing that their needs are often overlooked, unless they happen to coincide with those of another group.

II. CHATTANOOGA

A city of 169,565, Chattanooga is the center of a metropolitan area of 426,540 that includes five counties in Tennessee and three in Georgia. It is located in Southeast Tennessee, on the Georgia line, 20 miles from Alabama and 40 miles from North Carolina. It is about 100 miles from Atlanta and 130 miles from Nashville. The metropolitan area contains a black population of nearly 60,000, almost 90 percent of whom live within the city itself. Approximately 30 percent of the city's population is black. It is a city which is heavily industrialized, and has suffered accordingly in the recent recession. Its proximity to Atlanta has also made it in some respects a "satellite" city. It is, however, a city with a long history of citizen involvement and concern with social services.

The city's schools serve approximately 24,000 students, 46 percent of them black, and 54 percent white. (These proportions were reversed before the city annexed predominantly white areas of the surrounding county in the 1970s.) Over the past decade, the system has lost about 500 students each year. Until 1980, Chattanooga's School Board was appointed. (The Board was a "self-perpetuating" one, according to one member: applicants, who could be nominated by anyone, were screened by the Board itself.) Since then the Board has been elected by districts, and has been much more closely involved with the schools' operation. Typically, four or five of the nine School Board members are black.

A major issue on the political agenda is consolidation of city and county governments. Concerns are expressed that costs and taxes will increase, and services decline, if metropolitan government is adopted. Because nearly all the county's blacks live in the city, there is a feeling that the county residents will be "subsidizing" the black inner-city if consolidation is enacted. It might also require adjustments in current school bussing arrangements. Chattanooga has achieved court-required desegregation by means of bussing since 1971. The plan involves transporting children between contiguous school zones, creating pairs of neighborhood schools, one which serves kindergarten through third grades, and the other fourth through sixth. In addition, a system is in effect whereby a student can always transfer to a school where s/he will be in the "minority" racially. (This is referred to as "majority to minority transfer.")

In 1982, there were 233 live births to women under 18 in the city of Chattanooga, 97 to white teens and 136 to blacks. There were an additional 298 births that year to 18 and 19 year-olds, about half to blacks and half to whites. Nineteen percent of all births to Chattanooga residents were to adolescents.

Current Services for Pregnant and Parenting Teens

Currently, a comprehensive program for pregnant adolescents is run by the public schools in conjunction with the Family & Children's Services Agency. A pregnant seventh through 12th grade student may transfer to the Eastside Day School, which had a faculty of three and an enrollment of approximately 80 during 1983-84. Counseling is provided by caseworkers from the Family & Children's Services (FCS), which officially co-sponsors the program. No health care is provided on site, but nearly all pregnant students receive prenatal care, and deliver at Erlanger Medical Center, located within walking distance of the school. Enrollment in prenatal care is required for entrance to the school, and is monitored by staff. At any given time, a small proportion of Eastside Day School enrollees are also residents of Hastings House, a former Crittenton Home which merged with FCS ten years ago. The Crittenton/Hastings agency played a major role in the development of these services. Students who choose to remain in their home schools through pregnancy (a choice that is reportedly strongly discouraged by most principals) do not have any supportive services provided to them. The program does employ an outreach worker, however, whose job it is both to recruit students and to help them make the transition back to their regular schools after delivery. FCS continues to provide casework services after the girls have delivered and left the Day School program. No services are provided to girls who have not reached the seventh grade.

The County Health Department provides family planning services to low-income women, but has no special services for adolescents. Similarly, Erlanger Medical Center, run by the Chattanooga/Hamilton County Hospital Authority, has two neighborhood satellite obstetric and gynecology clinics, in addition to one within the hospital itself, but provides no clinic services exclusively for adolescents. The local office of the State Department of Human Services also provides a variety of services, with none especially for teens. Its staff is to begin implementing a "Parenting and Placement Service" shortly, but without any extra resources. Its major emphasis

is on the prevention of child abuse and neglect. The Department has done a few adoptions each year.

Service Climate

The service climate in Chattanooga is perhaps most easily characterized by the comments of several respondents. One administrator who had come to Chattanooga from a "progressive" state expressed surprise at finding social services so strongly supported here. Another, a child welfare advocate and service coordinator, pointed out that her work, bringing providers together, was not absolutely essential, because many of the same people already work with one another in numerous committees and organizations. As this individual put it, even if no one were available to organize them, many of these people "would drift back together eventually."

The United Way of Greater Chattanooga is a strong organization which has a major influence not only on the quantity of services provided, but also on the actual form those services take. In 1970, at the request of the local Crittenton Home, the United Way's planning arm conducted a study of services for "unmarried mothers," and recommended that "comprehensive services for school-aged pregnant girls" be established in the city to enable students to continue their schooling without interruption. Shortly after the release of this report, the Crittenton Home took the lead in expanding local services. In 1973, the United Way urged the Crittenton Home to merge with the Family Service Association and the Traveler's Aid Society. These three organizations then became Community Services of Greater Chattanooga. Five years later, Community Services of Greater Chattanooga changed its name to Family & Children's Services. When asked why the agencies were willing to merge, a local administrator noted that when agencies have "a gun loaded with 90 percent of their income pointed at their heads," they find it judicious to act.

Historical Development of Services

Chattanooga's original Crittenton Home opened its doors in 1881, near the center of town, with the goal of providing unmarried mothers with residential services for the last three or four months of their pregnancies. In 1910, it moved to a rural area on the outskirts. The present facility was built on this same site in 1931 to house 50 girls at a time, and indeed, it served about 150 girls a year until 1971. The Home

provided educational services for its school-aged residents beginning in the 1950s. Eventually, the school system agreed to give students credit for work done at the Home, if licensed teachers were used. Subsequently, the school system began to provide books and then teachers (first one teacher, then two, and later three) to the facility, but only residents were being taught. The first aspect of the Crittenton program that was open to the community was a summer school, funded by the Chattanooga Community Foundation, begun in 1970.

By 1970, the leadership of the Crittenton facility recognized that the demand for residential services was waning, that "the handwriting was on the wall" (although through this period their residence continued to operate at capacity). Their sense that it was time to "move outside of their own hedge" (as one respondent expressed it) led them both to originate the request for the United Way-sponsored study of services to unmarried mothers and then to use that study in expanding services.

The United Way report recommended that the Crittenton agency play a leading role in developing services for pregnant teens, and that "a vitally needed outreach worker program" be initiated to reach young women "of low social status, predominantly non-white," who were found not to be receiving needed services.[15]

An outreach position was funded by the local Junior League for three years with decreasing funds beginning in 1971. As Junior League funding was phased out, the United Way agreed to support the position. This position, and the woman who held it for its first ten years, proved crucial to the development of the program. A charismatic personality, this woman had worked in the local poverty program, and "her definition of outreach knew no bounds," according to those who worked with her. She would "buttonhole" adolescents on the streets, and tell them about the services available. By the time she left the position in the 1982-83 school year (shortly before her death), both the outreach role and the service were well established.

Until 1978, the Crittenton/Hastings House ran the alternative school on its own premises. Administrators viewed the school as a recruitment tool which attracted girls who could then be offered health and social services as well. The program's original teachers were Homebound instructors and ultimately the school system eliminated the traditional Homebound services to pregnant teenagers. The Hastings House, previously a residential facility serving primarily

white, middle-class girls, thus began in the 1970s to serve a predominantly poor black clientele. This new service orientation, while it may have rescued the agency from potential demise, inevitably imposed its own tensions. Eventually, the Hastings House facility "could no longer contain the crowds" of day students and in 1978, the school was moved to the vacant Westside School building. The program was able to expand its social work staff through Title XX funding.

Three years later, however, problems arose from several quarters. The program was forced to move from the Westside School and suffered major cuts in Title XX funding. Family & Children's Services could no longer provide social workers to work exclusively with the pregnant teens in the day program. Instead, six different workers began to include the teens in their caseloads. Currently about half the students receive individual counseling services, and all the girls participate in group sessions.

In the fall of 1983, the program moved to yet another location, its most satisfactory to date. A former city high school, the Riverside Building, is near Erlanger Hospital which gives it not only convenient health care but also very good bus service. Now referred to as Eastside Day School, the program occupies several classrooms along one corridor on a lower floor of the building. The services have survived the severe financial crisis of 1981 and seem reasonably secure. The biggest problem the program faces is its lack of on-site supervision in the person of a principal. Although there is a designated "lead teacher" among the three, she is less an authority than a peer. The three teachers are supervised by the Director of Pupil Services, who, in turn, is responsible to the Assistant Superintendent of Pupil Services.

The program's winter 1983-84 enrollment of 81 students included only 12 white students. Since there were (in 1983) 97 births to white school-age girls (under 18), and 136 to non-whites of comparable age, it is likely that white students are very much underserved by the program.

Factors Enabling and Hindering Service Development

Resources. The city's ability to develop and sustain comprehensive services for pregnant adolescents is due largely to its economic resources. Services in Chattanooga have benefited from the availability of funds from a variety of local voluntary sources, including the United Way, the Junior

League, and the Chattanooga Community Foundation. All have been willing to fund service components deemed important by the providers--that is, all have provided money in relatively flexible ways.

The United Way itself is a strong agency with a sizable endowment (nearly enough to support its entire overhead) and a 65 year history of achieving its campaign goal. The organization annually involves over 300 citizens in reviewing recipient agencies' operations and budgets and in recommending allocations. The United Way also supports the Metropolitan Council for Community Services, Inc., the planning agency which conducts studies and provides technical assistance. The Metropolitan Council is currently undertaking a community-wide assessment, with funding from city, county, and state. Excluded from United Way funding are any Catholic social services and any abortion providers.

Personal leadership has also been an important element in the development of services in Chattanooga. Three individuals have made particularly important contributions. Katharine Hastings became Director of the Florence Crittenton Home in January, 1968. Mrs. Hastings, whose father was a Federal judge, had earned her MSW during the preceding decade. Although her own facility was still operating at capacity (serving an almost exclusively white population, most of whom were not natives of Tennessee),[16] she saw other Crittenton Homes around the country falling on hard times, and recognized the need to change direction. The difficulty of her choice is made manifest by the number of similar facilities that opted to close their doors rather than begin to serve a population of girls who were uninterested in concealment, did not see themselves as "sinners," and planned to keep their babies.[17] The transition to the new program emphasis was accomplished with strong support from the agency's board. Mrs. Hastings became Assistant Director of the newly merged FCS in 1973, a position she still holds. The Florence Crittenton Home was renamed Hastings House in her honor in 1977.

Another key supporter of services for pregnant students in Chattanooga has been the Assistant Superintendent of Pupil Services. A member of the board of the Family Service Agency before and after its merger with the Crittenton Home, he is a strong advocate of the program. This administrator has worked hard to ensure pregnant students' rights in the system. He has especially had to advocate for them in terms of their right to remain in their zoned schools if they wish and their right to graduate with their classmates. Many

principals have wanted to exclude pregnant students rather than help them, and pregnant students still do not commonly remain in their local schools.

Finally, the man who became Executive Director of the newly created Community Services Agency in 1973, and has remained in that position ever since, has also played a significant role in supporting services to pregnant teens. A former administrator in the state's Department of Human Services, he is known throughout Tennessee for running an excellent agency. In 1981, when Title XX funds were cut back dramatically, he played a major role in restructuring casework services for the Eastside Day School students.

The news media in Chattanooga are supportive of social services. Both the Chattanooga Times (owned by the sister of New York Times publisher Arthur Ochs Salzberger), which has a liberal editorial policy similar to that of the New York Times, and the conservative Chattanooga Free Press, provide good coverage of human service issues and of the Family & Children's Services agency.

The existence of a strong voluntary sector in Chattanooga may be considered a resource in itself. The high quality of the leadership of the Crittenton/Hastings House and of the Family & Children's Services reflects the quality work and reputations of the agencies themselves. Similarly, the planning capability evidenced by the 1970 United Way report is indicative of a well-coordinated responsive voluntary sector.

Constraints. While Chattanooga has many resources on which to draw, it also is faced with a variety of constraints as a community. The policies--as well as the poverty--of the State of Tennessee are among these. Before Governor Alexander assumed office in 1979, there was virtually no state-level interest in the issue of adolescent pregnancy. Even since that time, despite visible initiatives from his office, there has been no state funding for special services for adolescents who are pregnant. The state provides no technical assistance or special encouragement to communities interested in serving this population. There has never been a coalition of service providers at the state level to advocate for school-age parents. Finally, and most important, the level of state support for basic health, education, and social services has always been minimal.

Local attitudes also constrain service development. As of 1970, it was official policy in the Hamilton County Schools to suspend a student who married, and even now, the principals of several city schools are said to informally discourage attendance by pregnant students. As several service advocates reported, "We need to be in there constantly fighting for our students' rights."

Recent funding shortages and cuts, in both the schools and the social service system, have further constrained the development of services. Although the crisis of 1981 was survived, it did leave the program with fewer teachers and casework services.

Conclusions

Chattanooga provides comprehensive services prenatally and counseling services postnatally to approximately 100 to 150 girls each year. (This assumes an enrollment of 80 at a time with each student attending for approximately one semester, but with slower "start-up" and "wind-up.")

Even in this relatively well-served city, there are significant service gaps. Fewer than 15 percent of these students are white, while over 40 percent of births to women under 18 in the city are to whites. The needs of the black population therefore seem to be better served than those of the white. There are no services for students below seventh grade, and no special services other than counseling once students return to their home schools after delivery. There is also little by way of linked services to those not in school.

There have been no evaluations of comprehensive services since the 1970 United Way report.

Chattanooga illustrates the kind of flexibility required for local programs to sustain funding cuts and meet changing service needs. Its relative success, in contrast to Knoxville, can be explained largely by the positive service climate, local financial resources, especially the Chattanooga Community Foundation and United Way, and community planning tradition and mechanisms. The local resources are especially important in a relatively poor state like Tennessee which lacks state program funding and where teenage pregnancy is of somewhat lower priority than more pressing health and welfare issues.

Volunteers from the Junior League and other organizations have played an important role in initiating services and

securing community support. A number of individuals, including direct service workers and advocates as well as administrators, have exercised leadership in the development of services.

As in every one of the sites with school-based services, there is some internal opposition to them, reflecting the stigma attached to adolescent pregnancy.

III. KNOXVILLE

Knoxville is a city of 175,000, the center of a metropolitan area of over 475,000. Just under 15 percent of the city's population is black, while not quite 7 percent of the Standard Metropolitan Statistical Area population is black. Over three-quarters of all blacks in metropolitan Knoxville live within the city. The physical and population center of Knox County, Knoxville is located on the Tennessee River in East Tennessee. It is the largest city in the area of Great Smokey Mountains, and indeed the largest city for 100 or more miles in any direction. In the 1940s, the city of Oak Ridge was built just a few miles outside of Knoxville, a middle-class community of 27,000 largely professional and technical workers in the nuclear energy industry. Between the spring and the fall of 1982, Knoxville hosted a World's Fair.

The home of the main campus of the University of Tennessee, with over 30,000 students, Knoxville's population is significantly better educated than that of the state as a whole: 61.4 percent of the city's (as compared to 56.2 percent of the state's) population has had four or more years of college.[18] The influence of the University is also apparent in the city's occupational structure and labor force characteristics. Nearly one worker in ten is employed by the state (compared to one in 20 for Tennessee as a whole), although obviously not all of these are University employees).

The occupational structure is skewed toward white collar jobs. Fifty-six percent of all workers are employed in professional, managerial, technical, sales, or administrative occupations, as opposed to 47.8 percent for the state as a whole. The city has also proportionally more service workers (16 percent versus 12 percent) and fewer "operators, fabricators, and laborers" (17 percent in Knoxville and 24 percent in Tennessee).

The city's population and its school enrollment have been declining over the past several years in spite of the fact that the city annexed part of the county in the early 1970s. The city schools currently have an enrollment of about 26,000 students, and are losing between 500 and 1,000 students each year. The county system--with a completely separate administrative and political structure--has about 25,000 students, and continues to grow, reflecting a shift in population from city to county. While approximately 15 percent of Knoxville's

students and teachers are black, Knox County's students are 99 percent white. The city's nine-member elected school board is currently composed of three women (two white, one black) and six men (all white).

Consolidation of city and county governments is a long-standing and continuing political issue. The concept has been rejected by both city and county voters several times in the past 15 years. Were the school systems to be consolidated, some costs might be reduced by the resultant economies of scale; however, other costs would increase because any program that existed in only one system would have to be developed in the other. (For example, the county offers driver education while the city does not, but the city has school nursing and counseling programs that are absent in the county.) Consolidation seems to be favored by the county power structure, but opposed strongly by the inner city residents, especially blacks, who see the likelihood of considerable dilution of their numbers and even greater diminution of their (not very significant) strength. Of the city's high schools, one is over 95 percent black, one is about half black, one is about 25 percent black, while the remaining five are predominantly white. The predominantly black high school is currently being renovated at a cost of several million dollars, which was interpreted by several white informants to mean that blacks see control over "their" school as an acceptable alternative to more complete integration, while the white majority is willing to pay to keep blacks in one place.

In 1982, there were 181 births to women under 18 in Knoxville, 118 to whites and 63 to non-whites. There were an additional 258 births to 18 and 19 year-olds, nearly 200 of which were to whites. Nineteen percent of all births in Knoxville were to women under 20. Nearly half (48.8 percent) of all pregnancies to women under 20 in Knox County, compared to only 30 percent in the state, ended in abortion in 1982. This high percentage of abortions probably reflects both the presence of the University and the existence of several high quality abortion facilities in the city.

Current Services for Pregnant and Parenting Teens

Knoxville currently has no comprehensive program serving pregnant adolescents. Residential services and a very small educational day program are provided at the local Crittenton Home. The Child & Family Services (CFS) agency

offers counseling to this population, as does Catholic Social Services.

Prenatal Program. The County Health Department's Prenatal Program, staffed by nurses, with support from the University of Tennessee Hospital, serves approximately 300 undelivered patients per month. This number is estimated to represent 90 percent of all indigent patients in Knox County. Between one-third and one-half of the women (100-150) are under 19, and about 20 percent (60) of them are black. There are no separate clinic hours for teens. Most (about two-thirds) of the patients who are served prenatally at the County Clinic deliver at the University of Tennessee Hospital under the care of physicians who they have not seen prenatally. The clinic employs a half-time social worker, who makes an effort to see all adolescents, as well as a nutritionist. The social worker refers patients to other agencies for needed services.

Parenting and Placement Project. The Department of Human Services office in Knoxville is beginning a demonstration Parenting and Placement project, with extra state funding, which includes four workers. The long-range goal of the service is to prevent child abuse and neglect, and to reduce the number of children entering the foster care system. They will be publicizing their services, and making them available not only to AFDC recipients but to any expectant parents or parents of young children, regardless of income. This service not only represents an expansion of traditional services to "unmarried parents" but will also be available to all parents, married or not. There will be both a new emphasis on adoption, and new classes in parenting for those who plan to keep their babies.

Pregnant students at Rule High School, one of the poorest and most integrated in the city, have for the past three years been offered specialized, bi-weekly, non-credit sessions taught in the school by local nurses in training. These sessions have been arranged by one of the school's guidance counselors but, according to respondents, are kept very quiet. Attendance at the classes, which cover prenatal education, nutrition, and other help topics, ranges between two and ten students.

Preschool Learning Center. Knoxville's newest service for pregnant and parenting students is a program which began operating, also at Rule High School, in January 1984. The new preschool learning center provides day care services for 15 pre-school children up to the age of three. Only

children of Rule's students may be enrolled. Students from other schools may transfer in so that their children are eligible, but first priority goes to students who are already at Rule. The Center also offers course credit to students (all the parents with children enrolled, and others who are pregnant or simply interested) who spend class periods learning about prenatal and child care, parenting, home management, and nutrition. The program is staffed by one full-time teacher and a teacher/administrator.

Teen Awareness Program. The Junior League has recently begun conducting a sex education program--called the Teen Awareness Program--in the high schools. The five-session series covers responsibilities of parenthood, birth defects, nutrition, risk factors in pregnancy, and fetal growth and development. They do not discuss abortion or contraception. This effort is co-sponsored by the local March of Dimes and the University of Tennesee College of Nursing. Instructors are League volunteers who receive special training, and go in pairs to health classes, usually at the tenth grade level.

Appalachian Adolescent Health and Education Project. Morristown, Tennesee, about 140 miles from Knoxville, is home base for a project funded by the federal Office of Adolescent Family Life Programs to provide education, counseling and referral services. The Appalachian Adolescent Health and Education Project serves 15 counties in East Tennessee, excluding Knox County. The project has apparently encountered resistance both from local service providers and from religious fundamentalists in the rural areas who consider the subject of teen pregnancy too private to discuss with outsiders. Although AAHEP has never served residents of Knoxville itself, providers in the city are well aware of its existence, and some are resentful of it.

Service Climate

Service provision in Knoxville is characterized by fragmentation and disharmony. Symptomatic of this was the fact that we were unable to find any service provider or administrator who could present a complete picture of services available to pregnant and parenting adolescents. Differences between Child & Family Services and the Crittenton agency are exemplified by the fact that when CFS submitted a funding proposal to the federal Office of Adolescent Pregnancy Programs several years ago, the Crittenton Home was said to have "lobbied against it." (Nor, apparently, had

CFS solicited advice or opinions from Crittenton or other agencies.) CFS workers, in turn, prefer to provide housing for clients who need it in foster homes which they supervise themselves rather than refer to the Crittenton Home. CFS also doesn't refer pregnant clients to the County Health Department, in the belief that services there, while of high quality, are "depersonalized." The Health Department, during the time when federal funding for family planning services was more generous, reportedly saw no need for Planned Parenthood, arguing that the two agencies were duplicating one another's efforts. Now that federal money has been cut back, there has been a merger of two local Planned Parenthoods, with the office now located in middle-class Oak Ridge, and there is virtually no funding for outreach services to teens. At the same time, outreach/sex education has also been nearly eliminated from the County Health Department's services.

From about 1973 to 1977, a number of Knoxville service providers met together as a task force concerned with the issue of adolescent pregnancy. Agencies represented on the task force included Planned Parenthood (then based in Knoxville), Catholic Social Services, Child & Family Services, Red Cross, March of Dimes, and the family planning component of the County Health Department. The task force never had a formal structure, and participation in it was neither assigned nor, in many cases, endorsed by agency heads. The task force apparently was interested both in seeing sex education programs developed in the Knoxville schools and in seeing Planned Parenthood begin to offer clinic services. (Until that time, they had done only sex education and outreach work.) Memories about the work of this task force were dimmed by time, staff turnover, and presumably by the fact that it was not a rousing success. Virtually no one who had been involved was still working in social services in Knoxville. The task force apparently disintegrated when Planned Parenthood opened a clinic, but it seems to have accomplished little of a lasting nature with respect to sex education in the schools.

The United Way in Knoxville has no separate planning arm, and seems to engage in few research and planning efforts. Although the agency has tried over the years to encourage agencies offering related services to merge, they have not been successful.

Historical Development of Services

There has been an ebb and flow in the provision of services for pregnant and parenting adolescents in Knoxville. Programs have come and gone, depending on funding and agency priorities, with providers at separate sites rarely cooperating with one another.

The contrasts with Chattanooga are many and varied. One of the most obvious is that between the Crittenton Homes. The Crittenton agency in Knoxville did not begin operation until 1965, and has had the same director for most of its existence. Like the Chattanooga Home, it now has programs both for pregnant young women and for adolescents who are in need of residential care for other reasons. Also like Chattanooga, it has been able to keep its occupancy rates high, partly by drawing from a large geographic area. (Its residents come from 20 counties in Tennessee, and from two others states as well.) Also, like all such programs across the country, it has shifted its focus as the number of white women planning to relinquish their babies has declined. The facility has in recent years begun to serve increasing numbers of residents who planned to keep their babies, as well as increasing numbers of black women.

In contrast with the Chattanooga situation, however, the Knoxville agency has not sought to increase services to local women in need of a day program. Only seven-day students were served at the Crittenton agency in the 1983-84 school year. Day students must provide their own transportation, and are taught together with residents in a single classroom by one teacher. There are no formal linkages with other community agencies serving the day students. The day program is not a comprehensive one; there is no individual counseling, and only very minimal health care monitoring or linkage. The day program is not publicized because, according to our respondents, if it had larger numbers enrolled, there would be no room for them. Members of the Knoxville school administration point to the Crittenton day program as their "answer" to the needs of pregnant school-age girls. The clear implication is that they want to be able, as one service provider said, to "check off" this problem, and believe that they have dealt with it. One reason for their reluctance to expand may be the limited resources available. The Crittenton Home recently looked to both the Junior League and the Levi Strauss Foundation to fund pieces of their program, and while Levi Strauss provided some limited support, the Junior League did not.

As mentioned above, the Child & Family Services Agency submitted a proposal to the Office of Adolescent Pregnancy Programs in the late 1970s for development of a "comprehensive" program. More recently, in the Spring of 1983, CFS ran a demonstration ten-week parenting group, which was intended to be a "support group." Child care was provided and the sessions' two co-leaders arranged transportation as needed. Even so, participation was very sporadic, with only two or three people coming consistently to every session, and attendance ranging from ten to 45 at the various meetings.

The latest service component for school-age mothers in Knoxville, the pre-school learning center at Rule High School, has secure funding for its first few years through the state Department of Education's Educational Consolidation and Improvement Act, Chapter 2 (federally-funded), as well as the Levi Strauss Foundation. The School Department provided space. The quantity and quality of controversy that surrounded the School Board's approval of this program, even after it had competed successfully at the state level, were remarkable. The program was conceived by the wife of a school board member, and a woman who holds bachelor's and master's degrees in child and family studies and is working toward a Ph.D. As the president of the local Junior League, she had been instrumental in establishing a peer tutoring project at Rule High School. That project has run for five years, giving her the opportunity to see the high school from the inside, and given the students a chance to know her and the other "rich white ladies" (as the students describe them) involved in the tutoring project.

The concept, unique not only in Knoxville but in Tennessee, was to provide both day care for students' preschoolers and parenting education for any interested students. Her idea was approved in theory by the local Curriculum Coordinating Committee in January 1983, "subject to available funding." In August 1983, a funding proposal was approved by the state Department of Education. When the school board was asked to hire this program developer to run the program, however, controversy erupted. The argument was put forth that the board could not legally hire a close relative of a member. School administrators in turn felt that she was the most appropriate person to run the program because she had both the educational qualifications and the inside knowledge of the school. Also, she had been volunteering her services for many years, had developed the program and succeeded at finding support for it, and "deserved" the job. Also involved in the controversy was the Superintendent, whose contract the board had just voted not

to renew. The group of board members who had voted against renewing the Superintendent's contract was nearly identical to the group that most strongly supported the proposed program.

The solution finally agreed upon was for the Alternative Learning Center, which administers special programs for 16 counties around Knoxville, to contract to legally run the program with the board member's wife as director. Control would still rest with the city school administration.

Factors Enabling and Hindering Service Development

Resources. The University must be counted among Knoxville's resources, or potential resources, although it is not clear how much of a contribution the University actually makes to the city or to the social service community. It does account for a sub-population in the city--students, faculty and alumni--which is better educated than the state average, as indicated by the statistics cited earlier. Although the University has schools of social work and nursing, they have not taken a direct, official lead in innovating services to this population. The University hospital is a major health care resource, serving a large number of obstetric patients and providing a High Risk Perinatal care program. Some informants suggested that the presence of the University would actually detract from service provision, because it would create a transient population without a sense of local commitment.

Knoxville also has a community of wealthy, socially concerned people who have had some impact on service provision. Perhaps most notable is the Junior League, which seeks appropriate service projects for its members. Currently, as noted earlier, the League is running a Teen Awareness Program in the high schools. In a city whose elected officials are loathe to advocate for or even to discuss "sex education," the League's willingness to step in is not insignificant. Members of the League have also worked with the local Children's Services Commission office, advocating services for children. The League also established the self-help tutoring project at Rule High School, which is still in operation.

Another illustration of the efforts of socially concerned individuals is the owner/director of the Knoxville Center for Reproductive Health. He and his family have been involved in the local mental health and family planning movements,

both of which are controversial in this conservative community. He himself was president of the board of the local Planned Parenthood affiliate at the time of the Supreme Court decisions that legalized abortion. He subsequently decided to leave his family's business and open an abortion/-family planning facility. This facility was mentioned by several informants as doing exemplary work. Planned Parenthood had considered establishing an abortion facility in the early 1970s, but decided against such action because it would have meant forfeiting United Way funding. When the Center for Reproductive Health was opened, Planned Parenthood reportedly was pleased that he operated it much as they would have themselves.

Knoxville providers do have another resource at their disposal. The Levi Strauss Foundation provides assistance to agencies in communities where the parent company has plants, Knoxville among them. The company sponsors a program of "Community Involvement Teams," through which employees receive some release time to do volunteer work at agencies they have chosen as a group. In support of the efforts of these "CITs", the Foundation will provide funding for programs of the employee-selected agencies. The Foundation currently has a particular focus on services to pregnant teenagers. The Rule High School day care/parenting education program has been the most notable beneficiary of the Foundation's resources in Knoxville; indeed, Levi Strauss provided for the program's first year what had been requested for a two-year period, allowing considerably greater freedom in purchasing supplies than state money alone would have. The Crittenton Home has also been granted some Foundation funding.

The final resource to be mentioned is the local United Way, which raised $3.4 million in its most recent campaign. The United Way supports 54 agencies in all, including both Child & Family Services and the Crittenton Home. It also has provided funding for the local Planned Parenthood affiliate, although controversy over this allocation has been "more continuous than not," in the words of one United Way official. Inclusion of Planned Parenthood is only acceptable because the local agency does not perform abortions, allowing the United Way to maintain that "what they're talking about (abortions) doesn't apply here."

Constraints. Factors constraining provision of services to pregnant and parenting teens are easier to identify in Knoxville than are resources. As in Chattanooga, state-level policies are among these.

Attitudes, especially those of school administrators, also constrain service delivery. One school administrator identified as having an interest in pregnant "children," as he called them, has no major interest in what happens to the (large number of) girls who are not served by the Crittenton day program. He indicated that the black "children" in Knoxville tend to stay at their home schools and keep their babies. They live at home with their mothers, and "don't ask for any special services."

A story told by a school administrator is particularly revealing of local attitudes. This person reports that a member of the school board, claiming to have had phone calls from parents opposed to the Rule High School day care program, asked, "Hey, what're you runnin' up there--a whorehouse?" The administrator's response was to say that "If that happens, I'll close it down." His main interest in the program is "preventing bastards," although he is also interested in helping those babies who have already been born.

The media also display attitudes which are not entirely supportive of service provision. Early on in the controversy over the hiring of the director of the pre-school learning center at Rule High School, for example, the News-Sentinel mentioned "School Board Member _____, who reportedly is trying to get a job for his wife with Knoxville City Schools." The paper published a number of stories on the Rule High School proposal, and on the issue of this woman's potential hiring, without ever citing her considerable qualifications for the job.

Lack of funds may be considered a constraint to service provision in the sense that if additional funding were available other services might be developed for pregnant teens. But it is not self-evident that this is the case. Only one project, the support group sponsored by CFS, was explicitly terminated for lack of funding within the past year or so. Even in that case, it is not certain that financial support would have created a viable program. No provider in the city mentioned any current effort to develop comprehensive services.

Some informants also observed that there is widespread skepticism in East Tennessee about initiating programs with federal funds. According to this view, federal funding is destined to be withdrawn, and when it is there are only two likely outcomes: either the project must end, with many hard

feelings, or it must be supported out of local funds, which imposes an unplanned financial burden on the community.

Conclusions

Knoxville is a city in which efforts to provide a full range of services to pregnant teens are not at the top of anyone's priority list. As one informant observed, providers do not like to deal with adolescent pregnancy comprehensively. They prefer to be able to "check it off" as an issue, and to feel able to say, "yes, we have services for them over there." Negative attitudes toward pregnant adolescents have constrained service development in the schools.

Each agency wants to do its "own thing." There is intensely felt competition among agencies, which has increased with recent cutbacks in funding. Knoxville lacks the kind of planning tradition and mechanism that has been so important in Chattanooga.

Very few, if any, pregnant adolescents receive truly comprehensive services. There is little or no organized effort to improve casefinding, outreach, referral services, or access. Consequently, those who get served are probably, as one respondent observed, the "cream of the crop," the most motivated, who have the personal resources to seek out what they need and make use of it.

NOTES

1. Statistical Abstract of the U.S., 1982-83. Washington, D.C., p. 437.

2. U.S. Census of Population, Vol. 1, PC-80. Washington, D.C.: Bureau of the Census, Issued September, 1981.

3. Statistical Abstract, 1982-83, p. 443.

4. The Book of the States, 1982, p. 509.

5. Ibid, pp. 192-193.

6. Statistical Abstract, 1982-83, p. 443.

7. U.S. News & World Report, February 28, 1983.

8. Tomorrow's Children. Governor's Task Force on Mental Retardation Prevention. Nashville, TN: Children's Services Commission, August 1982, p. 3.

9. Ibid, p. 20.

10. Interview with Mrs. Alexander, December 16, 1983.

11. Personal correspondence with Susie M. Baird, Assistant Coordinator, Healthy Children Initiative, July 6, 1984.

12. Interview with Mrs. Alexander.

13. Interview with Dr. Gunnar Dybwad, May 15, 1984.

14. Tomorrow's Children, pp. 11 & 18.

15. Report of Study Committee on Services to Unmarried Mothers, Joseph H. Lane, Chairman. Metropolitan Council for Community Services, Inc., Chattanooga, Tennessee, June 15, 1970, pp. 10 & 12.

16. Ibid, p. 25.

17. For discussion of maternity home closures and reduction in size, see H. M. Wallace et al., The maternity home: Present services and future roles. American Journal of Public Health, June 1974, 64(6), 574-575.

18. All sociodemographic statistics, unless otherwise noted, are from 1980 Census of Population, Vol. 1, Chapter B or Chapter C, PC80-1-. Washington, D.C.: U.S. Bureau of the Census, Issued September 1981.

19. Pregnancy, abortion and birth data were provided by the Tennessee Children's Services Commission, Nashville.

Part III.

Findings and Conclusions

Chapter 7. Comprehensive Services: The Concept and the Constraints

This chapter describes the financial, organizational, and political resources needed to establish and maintain comprehensive services at the local level. We begin with a brief historical review of the issue of social program coordination. We then examine the prerequisites for establishing local comprehensive services and assess the potential for meeting them. As we show, there is an absence of secure funding and limited constituent support for such programs, and these deficits seriously undermine their viability. Furthermore, the client population is an inherently difficult one to reach with conventional services. We conclude with the observation that few of the program interventions have been proven effective through empirical study.

The evidence from the study underscores the central conclusion of this chapter: the constraints are so formidable that only under extraordinary circumstances can localities succeed in putting together and maintaining comprehensive services for pregnant and parenting adolescents. Even where such "comprehensive" programs exist, there are likely to remain sizable gaps in the range of services offered and the proportion of the potentially eligible population served.

THE QUEST FOR COORDINATION

Historically, the search for effective social welfare coordinating mechanisms began with the development of services themselves. Coordination is the long sought-after solution for problems that can never be solved. There is an inherent tension between the development of specialized, professional services and the unique complexity of individual and family experience. With the current proliferation of specialized, compartmentalized services provided by experts, it becomes increasingly necessary to find some way to coordinate interventions for the whole person or whole family.

In theory, there are two basic approaches. One may bring or send the person to the services, through referral arrangements such as agency linkages and case management. Alternatively, the services may be brought to the client in a single location--the multi-service center approach. In practice, one is likely to encounter neither of these ideal types, but some hybrid of the two. Both models have been

employed in the past, as they are at present. For example, the friendly visitors, late 19th and early 20th century precursors of today's social workers, went into the community, making home visits, and assessing the need and moral qualifications for aid. They were instrumental in helping prospective clients gain access to services, sometimes from several sources. They coordinated the existing services, acting as intermediaries between clients and charity organizations in much the same way as the case managers of today. Part of the function subsequently became institutionalized in local, voluntary agency-supported social service exchanges that flourished from the 1920s through the 1950s. These exchanges maintained a central file on each client with a record of all agency contacts. This system informed each agency of the involvement of others so that they could, if they wished, coordinate their approaches and guard against duplication or fraud.

The second model, that of bringing the services to the client in a single location, has antecedents in the settlement house movement as well as in approaches relying on the institutionalization of client populations: the poor, aged, homeless or wayward children, the mentally ill, and unwed mothers. Many of the early Crittenton homes used teachers specially assigned by the public schools, and local physicians and nurses to provide the health and educational components of what would today be called a comprehensive, residential program. More recently, the single site model found expression in the neighborhood multi-service centers developed under the 1964 Economic Opportunity Act.

The comprehensive service model incorporated in the 1978 Adolescent Pregnancy Act combines features of both approaches. Some core services may be offered at a program site, with others being accessed through referral agreements. Coordination and interagency linkages are the mechanisms through which services, normally lodged in separate health, welfare, and education service systems are joined together. As public policy, the comprehensive services approach joins a venerable tradition of legislative attempts to solve the inherent coordination problem arising from the fragmentation of increasingly specialized services and the complexity of interconnected human needs. Indeed, it has become commonplace for federal social legislation to include some reference to coordination. Yet as the findings of this study demonstrate, coordination does not always occur through legislative fiat.

THE PREREQUISITES OF COMPREHENSIVE SERVICES

The abundant literature on social policy implementation that followed and critically assessed the expansionary era of the 1960s attests to both the optimism of national policy makers and the inherent difficulty of local program development. That literature suggests at least four basic prerequisites for the development and maintenance of local, coordinated interventive efforts:[1]

1. resources - health, education and social services; funds, staff, and facilities commensurate with the numbers served; and managerial skills to maintain and coordinate services;

2. political and popular support - or at minimum, acquiescence and toleration;

3. clients; and

4. an effective interventive technology based on sound, proven theory.

Each of these poses serious obstacles, as demonstrated by the study. Skill, dedication and hard work may help, but only within limits. To achieve all the essential prerequisites in one place at one time is an unusual and remarkable occurrence. That some localities fare better than others is less a reflection on the efforts of program proponents than a testimony to the inherent complexity and challenge of the task and the scarcity of necessary prerequisites. We now consider the severe constraints under which the programs seek to operate. We begin with a discussion of resources, and continue with a consideration of the political support, client characteristics, and intervention theory pertinent to adolescent pregnancy programs.

RESOURCES

The 1981 recession brought declining state revenues just as demands for health and welfare services sharply increased. The situation was made worse by cuts in federal programs and revenue limitation measures in two of the study states, Massachusetts and California. Public schools, a key component of comprehensive services, faced additional strains due to post baby boom enrollment declines and a commensurate

loss of state funding based on average daily attendance (ADA). Yet the firm impression we gained from those working with pregnant and parenting adolescents is that these adverse conditions, while perhaps somewhat worse now, are nothing new. The ups and downs of funding sources, constantly shifting priorities, and program initiations and terminations have become almost routine. The surviving programs are those with the requisite organizational capability, resources, and supportive environment to adapt to changing conditions. Yet as we show in Chapter 8, organizational survival can sometimes conflict with the interests and needs of clients.

In this section, we examine the limitations on requisite financial resources. We show how programs are constrained by the absence of basic support, the patchwork pattern of funding opportunities and actual or threatened cutbacks. Next, the lack of requisite local services including health, day care, housing, and financial assistance is assessed. Finally, we consider how these various resource constraints adversely affect preventive initiatives, service coordination, staff morale, and organizational capacity.

Operating Funds

Local service providers face severe obstacles in securing basic support. What little money is available must come from a variety of sources, each with its own set of strings attached. Because of the insufficiency and uncertainty of funding, providers assume a crisis management posture, operating from month to month with little attention to future planning.

Patchwork funding. Local comprehensive services must necessarily be pieced together and supported from a wide variety of federal, state, and local governmental funds, volunteer effort, local United Way, and public and voluntary in-kind and charitable contributions. This is even true for the very few programs supported by federal HHS Office of Adolescent Family Life (formerly the Office of Adolescent Pregnancy Programs) or Mott Foundation grants. In the local programs we studied, we identified more than 30 different sources of program support. (See Chapter 8, Table 8-1.)

Comprehensive services for pregnant and parenting adolescents have no single funding source, except for rare, time-limited "demonstration" project grants. State program funds in California, Michigan, and Massachusetts support only

some parts of programs and are severely limited in relation to need. Funds in California and Michigan are almost totally committed to those few programs that initially submitted successful applications; there are few, if any, opportunities for new applicants. (Massachusetts had just recently initiated its state grant support for local programs and had not yet confronted this problem.) In each of these three states, state allocations for teenage pregnancy services are considered in jeopardy.

Health services. For poor, pregnant teenagers especially, the lack of affordable health care often poses serious problems. In all but nine states, Medicaid is available for prenatal care for those women whose income level qualifies them.[2] However, bureaucratic roadblocks sometimes impede the determination of eligibility. For example, Massachusetts, like most other states, requires pregnancy verification by medical examination, not just a positive pregnancy test. Yet in at least one of our sites, Lowell, it was virtually impossible to obtain the required medical examination without being able to pay for it. An even more pervasive problem was the limited number of providers who would accept Medicaid or indigent patients, in part because of low reimbursement rates. In Tennessee, married women living with their husbands were ineligible regardless of need. Women in labor often appeared at local emergency rooms without having received prenatal care.

A number of factors were cited as limiting the availability of health care. They included: the trend toward privatization and absentee corporate management of community hospitals, resulting in the curtailment of services to indigents and the closing of unprofitable obstetrical wards; the declining interest of medical students in obstetrics and family practice; the limited number of providers willing to accept Medicaid patients; and the phasing out of indigent care obligations of hospitals built with Hill-Burton funds. In addition, individuals have lost insurance coverage due to unemployment. A number of family planning providers recently instituted fee increases, often resulting in a precipitous drop in the numbers of low-income women served. Some providers have been forced to reorient their services to a more affluent clientele in order to keep from closing down entirely.

Day care. Infant care, when it existed, was a major drawing card for adolescent mothers. While a few programs were able to offer infant care, the number of slots was severely limited in relation to the need. The limited

availability of subsidized day care in the United States is well documented. Organized care for children under three is a recent phenomenon, and the high costs, as well as a widely shared belief that the mother should care for her infant in the home, impede the development of infant care programs. Such programs cost as much as four times more than those for older children because of the need for richer staffing ratios. Consequently, funds that are available for day care tend to be allocated for programs serving older children where many more can be accommodated for the same cost. A further impediment to the development of infant care is the location of such programs in public school settings where non-educational services, particularly for pregnant and parenting women, are a low priority.

Housing and financial aid. None of the various definitions of comprehensive services mentions financial assistance and housing; yet for women from low-income families, these are paramount concerns. Only 20 states provide AFDC in the sixth or seventh month of pregnancy;[3] and then, depending on state regulations, it may be unavailable to women under 20 unless they can demonstrate their prior emancipation from their parents. Applicants need to have a permanent address to qualify for aid, but have difficulty renting an apartment without resources. Some welfare departments were reported to be unhelpful and unresponsive in facilitating the AFDC applications of young women. For example, in one Massachusetts locality, payments that were supposed to be made retroactive to the date of application were simply not provided by the local welfare office. California has a special optional AFDC program that provides assistance to qualifying couples for a three-month period only; afterwards, such couples frequently break up so that the woman and child may continue to receive assistance. In most other states, even such limited aid is unavailable for couples, thus contributing to the real or contrived dissolution of families.

In general, foster care was said to be in short supply. Workers in many different localities spoke of low-income teenage mothers moving around from place to place, staying with relatives and friends, but with no permanent living arrangements. Such impoverished young women are the least likely to participate in pregnancy and parenting programs.

EFFECTS OF CUTBACKS

All programs, without exception, suffered the effects, direct and indirect, of recent funding cutbacks. This was true in both the comprehensive and non-comprehensive sites. Some programs or program components had been terminated entirely. Examples include the Lowell Premature Parenthood Program, the Oakland Reproductive Health and Family Planning Forum, an Oakland infant care center, a Family and Children's Services support group, a Crittenton survival skills program in Knoxville, and county school programs in Knoxville and Santa Maria. Others like the Mott Foundation program in Oakland, and School Age Mothers (SAM) in Worcester, were without firm prospects for refunding. SAM was said to have recently "lost a funder every year," while both the other two Worcester programs were said to be on "shaky ground" as well.

More commonly, programs are maintained, but cuts are absorbed through reductions in staff and services. Summer programs are eliminated, as are transportation, outreach, and counseling functions. Hours are reduced and caseloads increased. School nurses and counselors, outreach workers, health educators, and social workers are usually the first to go. While the programs may still appear to be intact, the resulting dilution of services, elimination of outreach and transportation, and imposition of fees impose added obstacles for prospective clients. Only the most motivated and able, and those having financial resources of their own are likely to avail themselves of the program opportunities that remain. These circumstances reinforce the implicit tendencies of some programs to "skim" those clients who appear most likely to complete the program successfully.

Less Emphasis on Prevention

Another effect of budget constraints has been reduced emphasis on primary pregnancy prevention. In Chattanooga, public health/family planning clinics have a six-week waiting list. California advocates estimate an additional 55,000 pregnancies will occur in 1984 due to reductions in state family planning funds. Local Planned Parenthood affiliates have been particularly hard hit because of their limited funding base. They are excluded from many local United Ways, and the loss of state funding may force a shutdown of local branches and a reduction of subsidized services, both of which adversely affect those seeking help to avoid pregnancy.

Cutbacks and Coordination

Interagency coordination, difficult under optimal circumstances, becomes more challenging with limited or declining resources. When new funds are available, they provide incentives for participation in joint ventures and permit pay-offs to enlist the cooperation of otherwise recalcitrant participants. A scarcity of funds creates a zero-sum situation where prospective participants become competitors rather than seeking ways to work cooperatively. Non-mandated functions are particularly vulnerable. When adolescent pregnancy programs seek locally administered revenue sharing and other local funds, they compete with police, fire, street repair, sanitation, and other "essential" services.

Morale

The chronically precarious circumstances of most programs exact a heavy toll on staff morale. "The budget has a very negative effect on the motivation," said one administrator. "Everyone is being pulled apart by the cuts."

Managerial Skills and Organizational Capacity

The enormous administrative tasks requisite for successful program development and maintenance stretch to the limit the capacities of the constituent organizations and their staffs. In addition to recruiting the clients and running the programs, administrators must secure continuing financial support and sanction, coordinate activities with other agencies, and plan for future contingencies. These inherently difficult tasks are complicated by declining and uncertain funding, as well as the taint of an unpopular cause and a stigmatized clientele. Most of the program managers we interviewed were preoccupied with just trying to maintain their programs in some way. Some programs faced imminent demise. As one program director described the situation:

> "We're in very bad shape. We're facing freezes on hiring, purchasing, and all other kinds of things. Two of my staff have just gotten notice that they will not be continued. We blame ourselves in some ways for not having been able to get the thing together here. I'm trying to salvage it. Our morale is very low."

It is not surprising that crisis management is the order of the day.

Program managers face two extraordinarily difficult, if not impossible, tasks with respect to service coordination. First, they must somehow piece together a service continuum, often with crucial components missing. Second, they must make these separate pieces function as a coherent system from the perspective of the client.

We have been using the term service provider generically to indicate any agency (or its staff representative) directing services toward pregnant and parenting adolescents, as if all such entities were more or less the same. In reality, the relevant providers represent a diverse collection of organizations that differ on a number of dimensions. They pursue different missions: health, education, social service, financial aid, vocational training, etc. They are staffed by persons whose training and socialization produce distinct professional ideologies. They are potential and often actual competitors for funds and for clients. They have differing service ideologies, in some cases reflecting deeply felt religious convictions. Some favor encouraging adoption, and others readily accept teenage parents' keeping their child. Some stress prevention, and others services to the young parents and their children. Some accept abortion and encourage family planning, while others favor chastity. That any functioning system could accommodate such potentially divisive constituents is testimony to the commitment, skill, effort, and tolerance of those who succeed.

POLITICAL/ATTITUDINAL CONSTRAINTS

Adolescent pregnancy programs, like other social welfare services that depend on public and voluntary resources, require some measure of popular and political support, or at minimum, tolerance. In an era of limited resources and growing service needs, adolescent pregnancy programs must compete with a host of equally worthy claimants such as services to combat hunger, homelessness, child abuse, mental retardation, and infectious disease. Yet as an issue vying for attention and support, adolescent pregnancy confronts unique and severe obstacles. Despite, or perhaps because of the permissive attitudes toward sexuality that emerged in the 1960s, a powerful stigma is attached by many to adolescent sexuality, pregnancy, and parenthood. This stigma extends to services designed to prevent pregnancy or to assist

teenage parents and their children. Except for the service providers, the issue lacks a vocal constituency to lobby for resources. Service providers have come under strong attack from those who see their fundamental religious and/or political beliefs threatened by programs which they believe will encourage premarital sexuality. And finally, the resources needed to mount and sustain services are controlled almost exclusively by males who often share critical attitudes toward unwed, pregnant young women.

In the following chapter, we examine how some localities manage to overcome the obstacles sufficiently to develop and maintain services. Yet, even the most successful programmatic achievements are gained at some considerable costs. As we shall show, the political strategies used to develop and sustain programs in an inhospitable environment require compromises that weaken the programs and skew services away from the most needy. Here we discuss the obstacles that impede the building of political and popular support. These include: the stigma of teenage pregnancy and parenthood; the absence of constituency support for services; the dominance of male authorities who control resources and make policies; and fears engendered in response to radical activism of some anti-abortionists and family issue conservatives.

Stigma

Helping pregnant and parenting adolescents is an unpopular cause. Repeatedly, we were told that it is "not a popular cause politically," and that in the eyes of the public, service advocates are "out to promote pregnancy." Such negative views were more pervasive and intensely expressed in some areas, but they were found in all of our study sites. Usually, the more outspoken opponents were concerned primarily about abortion and sex education, but there was also a perception that <u>any</u> kind of services for pregnant and parenting adolescents contributed to "the problem" by condoning immoral behavior and bringing sexual matters to the attention of other adolescents. In fact, a number of respondents, particularly in the schools, spoke of the possibility that "contagion" might result from permitting pregnant teenagers to remain in regular school settings. The need to isolate pregnant students in order not to offend influential adults was frequently cited as the primary rationale for maintaining separate programs. As one informant put it, "the program is segregated because many in the school administration don't like to see 25 pregnant students." Similarly, programs depending on donated space have had

frequent moves, often because of objections from church members or agency personnel about the presence of pregnant teens. According to one informant, one program was evicted from a social agency because of "the pregnant bellies in the cafeteria."

The stigma, as far as we could tell, was essentially an adult phenomenon. According to those we interviewed, the teenagers found acceptance among their peers. As one adult told us, expressing some dismay, "There's no stigma for them. They take their child back and show off the trophy." (It should be noted that we were unable to interview any of the teenagers ourselves, and such reports, while consistent with empirical studies, are second-hand.) The ready acceptance of pregnancy and parenting among the teenagers was a source of concern for some service providers. Those interested in promoting adoption often seek to isolate pregnant from parenting teens. They fear that peer pressure from those who keep their infants will inhibit consideration of relinquishing for adoption by others. This is perhaps one of the reasons that programs serving the two populations, like SAPID and Pregnant Minor Programs in California, are so difficult to combine, despite the ostensibly sound administrative reasons for attempting to do so.

There were some disturbing reports indicative of the guilt and suffering experienced by at least some pregnant adolescents. For example, a pregnant Lowell student was said to have delivered in the Dracut State Forest. Several well-publicized abandonments of newborn infants in Tennessee were a major source of concern for officials and service providers there. Also, in Tennessee, several of our respondents noted the plight of young women from fundamentalist religious families. In the words of one informant, "[They] have babies too. But they go through such emotional abuse, they probably should have those babies adopted. Sometimes the parents say 'you've sinned' and they make their daughter give the baby to someone else in the church."

Lack of Constituency Support

The only groups actively lobbying for services for pregnant and parenting adolescents are current and potential service providers and others who have a professional interest in the issue. Such advocates may be suspect in the eyes of some legislators as being self-serving. The adolescents and their families do not constitute an organized interest group

seeking help from the political system. This is likely due, in large measure, to the stigma attached to adolescent pregnancy. While other stigmatized groups such as welfare recipients, homosexuals, and the handicapped have at times successfully advocated on their own behalf, pregnant teenagers face a combination of constraints that precludes group activism, not the least of which is their age. Their diversity, in age, race, family and socioeconomic status, religion, pregnancy outcomes, and life goals makes it difficult to forge an action group to meet their divergent needs. Pregnancy is a temporary condition, and pregnant adolescents, except when brought together in special programs, are scattered in small numbers throughout the community. The adolescents themselves are without political resources, and their parents have little to gain by calling attention to what some would consider a failure of parental supervision.

The Dominance of Male Authorities

There is a very clear gender-related division of labor with respect to services for pregnant and parenting adolescents, and this has profound implications for how the issue is handled. Almost without exception, the direct service workers are female--teachers, nurses, social workers, health educators, members of the so-called semi-professions--while the policy makers, funders, and administrators--legislators, state and local agency executives, school superintendents, and secondary principals--are predominantly overwhelmingly male. We learned that many of the women caregivers were drawn to the issue because of their direct contact with and concern for the pregnant adolescents. Some reported personal experiences, their own or those of close friends and family members, that predisposed them to empathize with the problems faced by very young, pregnant women. This personal concern perhaps accounts in part for the extraordinary sense of mission and dedication with which these women approach their work responsibilities.

The situation of those who are the service and resource gatekeepers is quite different. Above, we mentioned the stigma attached to adolescent pregnancy. Insofar as our study respondents are concerned, these condemnatory attitudes, reported in all the study sites, were almost invariably expressed by or attributed to influential males. In the schools, we heard repeated male concerns about having illegitimate children on school campuses, and about pressures to punish and exclude pregnant girls despite both legal prohibitions and the possible loss of reimbursements based on

attendance. In one instance, a male principal refused to permit girls who had participated in a special pregnancy program to participate in graduation exercises; in other cases, women returning to their regular high school after delivery were denied the opportunity to take part in school activities. Referrals to programs, whether school-based or not, rarely came from school counselors or principals. Interestingly, the condemnation of the young mothers did not extend to the less visible fathers.

There are indeed notable examples of influential and sympathetic males who have taken on the issue within the schools, in state and local government, and in public and voluntary social agencies. Without such support, we doubt that there would be very many programs in existence. Yet, in almost all instances we found a common pattern of conversion of men to the issue by women. In other words, males would learn about the problem and become supportive of programs and services through the intervention of a female, frequently a wife, aide, or co-worker. The extent to which such conversions had been effected was a key determinant of the relative success of program development activities.

Family Conservatives and Radical Activism

Some recent changes in family patterns--the large influx of women into the labor force, the rising divorce rates, and the growth of single-parent households, as well as perceptions of an epidemic of teenage pregnancies--threaten those who strongly value the traditional two-parent family. The stigma that is attached to adolescent pregnancy may reflect these concerns. However, a vocal minority of radical activists have pressed their views outside normal political channels. For example, there was a sharp increase during 1983 and 1984 in acts of terrorism against abortion clinics. None of our study sites had experienced the fire bombing and arson that have occurred elsewhere, although Bay area family planning clinics had been vandalized and patient records destroyed. However, respondents in about half the study sites had been subject to other forms of harassment. The primary targets were reported to be school library and text books that some found offensive, family life education programs in schools, and abortion and family planning clinics. In Elk Grove, a fundamentalist group was said to have attempted destroying family life education films used in the schools. In Fresno, a local group was said to monitor books "looking for phallic symbols." In Santa Maria, the former school superintendent was reported to have ordered the

burning of copies of Our Bodies, Ourselves in response to "right wing pressure." The local Tele Med system there provides no information on sexuality, generally among the most frequently requested categories in comparable call-in taped educational message systems. Book burning and banning incidents, while more frequent in California, were also reported at one of the Massachusetts and Tennessee sites.

More common were efforts directed against family life education programs in the schools. Activists in California were successful in blocking a proposed state family life curriculum, and in Tennessee and Michigan, proposed family life content was made optional for local districts to avoid local political opposition. Massachusetts is in some ways the most conservative of the four states on issues related to sexuality. Its state health agency lacks a family planning department and it was cited in 1979 as out of compliance with Title V regulations (Maternal and Child Health) for insufficient spending on family planning. State mandated sex education is not an issue as it is regarded as not politically viable.

In five of the ten sites local activists were reported to have demanded equal time to counter sex education presentations in the schools. They harassed those making the presentations, threatened school board members, and picketed family life education lectures in two of the study sites. Family planning and abortion clinics were routinely picketed and clients were videotaped, photographed, and shouted at in about half the sites. One United Way director told us of receiving about 20 inquiries at campaign time each year from activists posing as women seeking abortion services as a way of testing the agency's policies. (None of the United Ways in our study sites supported agencies performing abortions.) At the time of our study, a Detroit group successfully blocked implementation of a Girl Scout sex education program by threatening a boycott of the annual cookie sale.

The conservative groups active in our study sites varied widely in their strength, composition, goals, and ideology. Some right to life organizations were considered by program advocates to be moderate, constructive, and accommodating in their strategies. Some were supportive of services to pregnant adolescents and their children as an alternative to abortion. Other groups were effective in keeping sex education out of the schools or limiting its scope and content. They were also effective in blocking local public and voluntary support for family planning and abortion.

The assaults against abortion and sex education were often generalized against any activities relating to sexuality, including services to pregnant and parenting teenagers and their children. Though service providers in this study generally kept clear of abortion-related activities, they frequently felt the effects of these attacks. For example, a school board member characterized services for pregnant teenagers as "immoral... the devil's work." An administrator told us, speaking of attitudes toward services, "The attitude here is that the more I know about it, the more I'm going to do it. I had one guy insinuate that if they got pregnant, we ought to just shoot these girls." Another administrator told of a local services program coming under attack as "endorsing immorality." As mentioned earlier, such services lack a vocal constituency, even when there is general support. In the words of a school board member, "It's always been the minority, but the majority has allowed themselves to be scared off."

In the conventional view of interest group politics, groups contend in the electoral, legislative, and administrative arenas for enactment and implementation of policies they favor. In the case of services related to adolescent sexuality and pregnancy, the weakness of the pro-service constituency and the militancy of anti-service activists puts service providers and advocates on the defensive. This has several unfortunate consequences. The common response of service providers is to "keep a low profile." Consequently, programs are everywhere in retreat. Instead of conducting aggressive outreach and recruitment, administrators often limit these activities for fear of attracting the attention of extremists. While many providers would prefer placing more emphasis on prevention, particularly sex education and family planning, these activities are also avoided or kept quiet for fear of jeopardizing other services.

CLIENT POPULATION CHARACTERISTICS

As any parent knows, adolescents are a challenging group to work with. In forging their own identities, they question adult standards and sometimes rebel against adult authority. Peer influence is powerful. Teenagers at times show the judgment and capability of adults, and at other times the dependency and naivetè of children. Pregnant and parenting adolescents suddenly find themselves thrust into adult roles without the preparation, support, and social sanction necessary to perform them.

Complicating the task of reaching and serving the teenagers was the fact that in several instances, programs shifted clientele, moving from one racial or ethnic group to another. Sometimes this occurred because of a shift in program emphasis, as with the phasing out of residential programs serving white youngsters and the development of day programs serving a predominantly black clientele. Sometimes it reflected underlying population shifts, as with the increase in the Hispanic population in Lowell and Worcester or the influx of Hmong refugees in Fresno. Most often, shifts of clientele followed administrative actions motivated by budget cuts, as with the elimination of transportation and reimbursement for suburban adolescents who had previously attended central city programs; or with the shift of programs from one location to another. Such shifts challenged the capacities of programs to adapt. Many did so successfully, although constrained both by a lack of experience and by the difficulty of staffing programs on short notice with workers from the appropriate ethnic groups. This was particularly true of school-based programs where staffing was based on seniority and where budget cuts had disproportionately eliminated minority staff.

In several instances, agencies had difficulty making such transitions, and in two cases, rationalized this by suggesting that the new potential client groups (blacks and Hispanics) did not really need or desire their services. We heard, for example, "Hispanics tend to nurture each other through a more extensive use of the family... They don't need as much support." Hispanic staff or volunteer translators were said to be unnecessary because, "The kids want to assimilate." Ironically, in places where there is strong conservative opposition to services, it is sometimes less strong when the clients are poor minority group members. "As far as the community is concerned, the more 'bad' a kid is, poor, Hispanic, out-of-school, pregnant, and so forth, the more [the agency] is permitted to deal with him."

INTERVENTIVE TECHNOLOGY AND THEORY BASE

In the previous sections of this chapter, we have considered the many constraints that may impede the development and maintenance of programs and services for pregnant and parenting adolescents. There remains the essential question of their effectiveness. Can these approaches produce the concrete results suggested in statements of program goals and objectives? Do the proposed interventions

work? We did not set about to assess the effectiveness of the programs we visited and observed. Nonetheless, we were struck by the relative absence of evaluations of programs' effectiveness and the ready acceptance of a multiplicity of unproven and sometimes conflicting theories and assumptions about the effects of program operations.

The comprehensive services model assumes that timely interventions by health, educational, and social service agencies will help the young woman to: make an informed decision about the resolution of her pregnancy and implement that decision; receive early and adequate health care and deliver a healthy baby; learn and put into practice good parenting skills; avoid future unintended pregnancies; learn about good nutrition, and provide for the nutritional needs of mother and child; complete her high school education or as much of it as possible; and prepare for adult roles including marriage and a career. There is scant evidence on program effectiveness in achieving these goals.

An Urban Institute evaluation of 30 OAPP-funded projects indicated that clients' infants experienced a one year mortality rate "between that for white and non-white infants in the nation as a whole," an apparently good result in view of the high risk population targeted by the projects. The study also found somewhat lower rates of birth complications and low birth weight for clients and their babies. However, the projects showed little or no effect with respect to educational continuation and completion, welfare dependency or employment measures.[4] As the authors point out, their findings are limited by the absence of a control group and missing outcome data.[5] While they lauded the project emphases on health services--more than 80 percent of the clients were said to have received "pregnancy tests, maternity counseling, and prenatal care and delivery services"--they concluded that the projects "may not offer needed assistance to young mothers with the very real problems of adjusting to life with a new baby, changed family relationships, and attempts to stay in or return to school."[6] The multiplicity of goals exceeds the capacity of any program, no matter how exemplary. In fact, the empirical evidence suggests that most of the ill effects associated with adolescent pregnancy are rooted in poverty, a condition not explicitly addressed by any of the programs and services studied here.[7]

Further complicating the tasks of adolescent pregnancy programs is the diversity of the potential client population. Age, family, socioeconomic status, race, religion, educational,

career, and family aspirations make adolescent pregnancy an individual, unique experience with varying consequences for different women. Customarily, programs target services toward one segment of the potential client population, ignoring the rest. For example, most of the programs we visited served adolescents who were still in school rather than drop-outs. Many excluded teenagers under a certain age or grade level.

Many of the programs were initiated by women in the schools or social service agencies responding to the crisis that the unintended pregnancies created for the pregnant adolescents.[8] A major concern, reflected in the emphasis of many of the programs, was to offer a safe, supportive environment for the prospective parent, with other goals being subsidiary.

Our interviews unearthed an amazing array of theories, implicit and explicit, about what various approaches were supposed to accomplish. For example:

> Everyone's talking about their needs for information and access to things like health care. But, in my view, that's not what they need. They need help with the transiency of their relationships. They know how to use birth control, they're just not willing to do it.
>
> The failure of these clients to come consistently to the sessions is very symbolic with how they perform in the world.
>
> Senator _____'s belief is that if she's not able to raise the child, she should get someone to take it over.
>
> We're looking at the incentives for adoption. We know peer pressure is huge to keep the baby after pregnancy. The adoption statute we would favor would be to reassure the pregnant teenager that her child would be well taken care of.
>
> Our role is to try to offer a bridge, a continuation for the holding period between when they get pregnant and when they deliver.

> Subconsciously, these girls have kids to verify their own identity. It's our job to help them have a more positive identity. We're not a family planning agency and we're not teaching them about birth control.
>
> We've moved toward therapy and away from primarily education. We found that although our workers were teaching about child care, decision making, contraception, etc., without therapy, the clients didn't change... they were still having kids.
>
> I'm not sure what the goal for the program is. To have them graduate from high school? Be able to care for their babies? Not get pregnant soon? Not corrupt other girls with a deviant lifestyle?
>
> The fact that they come, that they care, they open up their lives, that's what we consider success.

None of the programs studied conducted evaluations of their services aside from keeping basic enrollment statistics and in several instances, follow-up data on school completion and repeat pregnancies. None compared program enrollees with a control group. This is no reflection on the service providers, as the resources for carrying out program evaluations were lacking, and the incentives minimal. In the Oakland perinatal project and the Mott Foundation-supported program, evaluations had been required by the sponsors and funds were set aside for that purpose. In both instances, however, the evaluations were hampered by the short duration of the intervention and the difficulty of conducting the evaluations when the programs had terminated. Massachusetts, on the other hand, provided state funds for evaluations of programs supported both by the Department of Social Service and the Department of Public Health during the 1982-1984 period, but these had not been carried out at the time of the study.

At times of program entrenchment, when planning, forecasting, and evaluation capacity is needed most, it is least likely to be available; administrative and planning functions tend to be cut first in order to maintain services.[8] For the most part, the only mention we heard of program evaluation was from lobbyists and others seeking resources from legislative bodies. They decried the lack of statistical and cost-effectiveness data that would support their funding requests. Yet without exception, the service providers and

their supporters firmly believed that the programs "worked," and saw little need to confirm this empirically.

Conclusion

Those seeking to develop and maintain services for pregnant and parenting adolescents face severe obstacles. Local programs that seek to link services from several separate service domains are inherently difficult to establish. The difficulties are compounded in the case of pregnant and parenting adolescents. Essential service components are lacking, and the multiplicity of agency goals, auspices (public, private, and proprietary; local, state and national; religious and non-sectarian), and funding constraints impede coordination. It is a decidely unpopular cause. Any program activity may serve as a lightning rod for extremists who generalize their opposition to all efforts to assist pregnant adolescents. The clients and, by association, programs to assist them, are stigmatized. Except for a small core of service professionals and advocates, there is no vocal constituency working on behalf of the adolescents. Programs and services staffed largely by women must obtain resources and sanction from male-dominated institutions that are not inclined to assign the issue high priority. Finally, the various programs and services use many different interventions, few of which have been proven effective.

That some programs are established and continue to operate is remarkable, in view of the obstacles. How they are able to get started and survive is the subject of the next chapter.

NOTES

1. Examples include: Eugene Bardach. The implementation game: What happens after a bill becomes a law? Cambridge, MA: MIT Press, 1977; Gordon Chase. Implementing a human services program: How hard will it be? Public Policy 27, Fall 1979, 385-435; Jeffrey Pressman and Aaron Wildavsky. Implementation. Berkeley, CA: University of California Press, 1979 (rev.); and P. Sabatler and D. Mazmanian. The conditions of effective implementation: A guide to accomplishing policy objectives. Policy Analysis 5, 1979, 211-220.

2. Children's Defense Fund. American children in poverty. Washington, D.C., 1984, pp. 67-68.

3. Ibid.

4. Martha R. Burt et al. Executive summary, helping pregnant adolescents: Outcomes and cost of service delivery. Final report on the evaluation of adolescent pregnancy programs. Washington, D.C.: The Urban Institute, February 1984, p. 5.

5. Ibid, p. 11.

6. Ibid, pp. 3-4.

7. See, for example, Frank F. Furstenberg, Jr. Unplanned parenthood: The social consequences of teenage childbearing. New York: The Free Press, 1976, esp. Ch. 11, Social policy; and Lorraine V. Klerman. Adolescent pregnancy: A new look at a continuing problem. American Journal of Public Health 70(8), 1980, 776-778.

   For an excellent overview of the research on adolescent pregnancy, see Elizabeth R. McAnarney, M.D. (Ed.). Premature adolescent pregnancy and parenthood. New York: Grune and Stratton, 1983. In Chapter 21, Elizabeth R. McAnarney, M.D., and Henry A. Thiede, Adolescent pregnancy and childbearing: What we learned during the 70s and what remains to be learned, the authors state: "studies from the 60s did not isolate the effects of age from race, socioeconomic status, legitimacy status, etc., and concluded that by virtue of being adolescent, the mother was at high risk of poor

outcome, as was her baby." However, as McAnarney and Thiede show, adolescent mothers, "even those less than 15" are not substantially at greater medical risk than older mothers of similar SES and race. In fact, given good care, age 16 to 19 may be considered an ideal time obstetrically.

8. See Chapter 9. Zellman found a similar pattern in her study of school-based programs. See Gail L. Zellman. The response of the schools to teenage pregnancy and parenthood. Rand No. R-27 59-NIE, Santa Monica, CA, April 1981. Zellman states, "Given the many factors constraining the school district's response, the presence of a motivated person seems a necessary condition for the establishment of a special program... the form and quality of this person's ideas usually determine the form and quality of the district's program," p. viii.

9. Charles H. Levine. Organizational decline and cutback management. Public Administration Review, July/-August, 1978, 316-325.

Chapter 8. Overcoming the Obstacles: Conditions and Strategies for Successful Program Initiation and Maintenance

Despite the many obstacles, a number of localities have developed comprehensive programs. In this chapter, we examine how they did it. The study shows clear differences between those localities that have succeeded in developing and maintaining comprehensive services and those that have not. Before discussing these differences, it is important to note the common elements found in all sites.

First, it must be stressed that the categories comprehensive and non-comprehensive, while conceptually distinct and dichotomous, represent points along a continuum. Some programs are more or less comprehensive than others. None of those we observed achieve the ideal type models suggested by the various definitions of comprehensiveness discussed in Chapter 2.

Second, all the programs are in flux, adjusting to the various contingencies that threaten their continuation. In tracing the origins of the programs, one sees turbulent histories. Specific services, programs, and funding sources come and go; program sponsors, locations, and clientele change. Several of the study sites might have been placed in a different category had the study been conducted earlier or later. Oakland is an example. Based on current programs and services, it did not qualify as a comprehensive site, although it did have a number of good programs in operation. Had we visited a few years earlier before the demise of several key programs, or should we return in a year or two, when (and if) some of the planned activities are successfully launched, it might well qualify as comprehensive. In sum, frequent ups and downs--in funding, numbers served, and scope and quality of services--were experienced by all programs, and the situations that occurred at the time of the study could be expected to change.

Third, while leadership is an important factor, the relative success of the programs cannot be attributed to differences in leadership and effort alone. We were consistently struck with the personal investment of service providers in their activities. This was equally true in the non-comprehensive and comprehensive sites. In all sites, we found a high level of dedication as shown by a strong sense of mission, and a willingness to endure personal hardship with little material reward or recognition.

Fourth, program success is related to the presence or absence of essential community resources. These resources include a minimal level of basic health, welfare, and social services; the support of local foundations, United Way or other flexible funding sources; a culture, sustained by prominent citizens, supportive of local charitable social services; a strong voluntary sector; personal and organization resources for coordination; and supportive state policies backed by funds for local programs. These conditions are relatively fixed, at least in the short term. They are either present or not; most often they lie beyond the ability of service providers, individually or collectively, to affect, although Fresno offers an example of a growing community that has increased its capacity for social problem solving. The essential point is this: to a large extent, relatively fixed community conditions determine the capacity of localities to develop and maintain comprehensive services. This is not to say that the presence of these characteristics guarantees the services, or that localities lacking such characteristics cannot develop comprehensive programs. Rather, these conditions, discussed below, are associated with success, and when absent, constitute significant barriers to program development.

The study revealed a number of administrative and political strategies that were successfully employed to overcome or circumvent the obstacles described in Chapter 7. Within limits, many service providers were able to mute opposition, build support, and maintain resources and programs in the face of funding cutbacks. They used such strategies as linking adolescent pregnancy to other issues, or sometimes concealing or medicalizing it, converting male gatekeepers, and enlisting elite support. In this chapter, we examine the various strategies employed and assess their impact on services and programs. We discuss community characteristics associated with successful development of comprehensive services, and then turn to the strategies used to overcome or circumvent the constraints.

CONDITIONS ASSOCIATED WITH SUCCESSFUL PROGRAM DEVELOPMENT AND MAINTENANCE

Leadership

Effective leadership is associated with successful programs. Observers are likely to credit program success to its leadership, particularly when the leaders are highly

visible. Our study confirms this association for the sites we visited. Yet we observed instances where leadership was insufficient to overcome the obstacles to program development. We also learned that crucial leadership roles and functions tend to be distributed among many individuals and organizations. This finding, with respect to multiple leadership roles, confirms the insights of experimental studies of group behavior. Such studies challenge the notion that leadership is a single trait or innate personal attribute.[1] It is instead more useful to think of leadership as being shared among group members who take on particular leadership functions or roles for which they may have aptitude. Small groups may have task leaders who focus on the problems to be solved, socio-emotional leaders who attend to group feelings and morale, leaders who help forge compromise and build consensus, leaders who provide innovative ideas, and leaders who mediate the group's external relations. Not only are these roles and functions shared through an informal, tacit division of labor; they may, at times, be passed from person to person. This is basically what we found with respect to the interorganizational program development tasks. There were numerous leadership roles and functions involved. In the more successful programs, leadership was exercised by a number of individuals who had developed cooperative working arrangements based on long experience.

This is not to deny the unique contributions of those outstanding individuals who were generally acknowledged to have played essential roles in program development. Such key persons were variously described as "outstanding," "exceptional," "dynamic," "charismatic," "strong," "hard-working," "dedicated," "a one-woman army," "a veritable legend." Frequently, existing services could be traced to the activities of a few such outstanding individuals. But even in these instances, we found many persons, some unheralded, whose involvement was crucial in developing some essential program ingredient.

One additional characteristic of effective leadership deserves mention. In the more successful localities, individuals performing leadership functions lived in the same community and had worked together over the years on a number of issues. They often served together on various local civic committees and agency boards. In other words, they knew each other well. This is in sharp contrast to those places, less successful in maintaining services, where most of those in leadership roles were originally from outside the area, lived out of town, and where there was a rapid turnover in leadership.

The specialized leadership roles we identified were as follows:

Administrative leadership. This refers to those persons in administrative roles who were particularly effective at internal management, program development and planning, and coordinating with other organizations.

Grantsmanship. We identified a number of persons in various positions who were particularly skillful at seeking out funds and packaging collaborative, multiple funding arrangements. Such skills are most important given the bewildering variety of funding sources, some of which have little if any discernable connection with adolescent pregnancy. Almost invariably, those exercising grantsmanship skills were program advocates or providers. We found no grant writers who simply sought to access funds to enhance local program budgets as an end in itself.

Political leadership. One of the essential program development tasks is to secure the political and popular support necessary to enable programs to go forward. Some program advocates were particularly effective lobbyists. Also significant was support by local socioeconomic elites. Elite sanction, if not outright support, contributed to program success in several of the study sites. Leadership by locally prominent persons lends credibility to efforts that might otherwise be suspect in the eyes of local citizens and politicians. The support of key state legislators and executive branch administrators was important in providing general program sanction and supporting specific relevant legislation. In several instances, individual legislators also advocated for expanded coverage, and on one occasion, sought to protect a local program from cutbacks.

Institutional leadership. In several instances, local institutions, most notably the schools and United Way organizations, and in one case, the juvenile court were instrumental in facilitating collaborative program arrangements. Such cases were all the more notable because they were rare. Usually, the absence of leadership from community institutions constituted an obstacle to be overcome.

Outreach. Clients are an essential program prerequisite. We encountered a number of individuals who were especially talented at locating and recruiting them. One legendary figure, a veteran of anti-poverty programs of the 1960s, was said to have recruited pregnant teenagers on the street. Another "plucked them" out of local hospital waiting rooms.

Such aggressive recruitment often spelled the difference between programs that served the most motivated from those reaching the more needy and more challenging clients.

Securing Funds for Program Support

Data limitations. Identifying and tracing the sources of funds for program support would constitute a major study in itself. We did ask the service providers and others we interviewed about the sources of support for their programs. The information obtained was instructive, but necessarily incomplete.

Public health funds tended especially to be under-reported at the local level. Only one of the programs in our sample was health-based, and our respondents were, in general, least well informed about sources of support for the health services included in the referral network. Furthermore, with the initiation of federal health block grants, local health providers had difficulty in distinguishing between state and federally-funded programs that came to them under state initiatives. Other programs, like Medicaid (Title XIX) and AFDC, were so much taken for granted that providers rarely mentioned them except to complain about their limitations.

We did not attempt to trace the support of each local contributing agency unless it was clearly earmarked for adolescent pregnancy programs. This no doubt resulted in an underestimation of agency contributions. For example, local school districts were almost never mentioned as funders, except in administering special grant programs, but in every site with a school-based program, there was inevitably some local contribution of space, staff time, books and supplies, etc.

Funding sources. Table 8-1 shows the sources of funds, currently and historically, for each program as identified by our respondents. Most striking is the number and variety of funding sources. With the possible exception of Title XIX (Medicaid), there is no single source used by all the programs; each program drew upon a mixture of sources. As one would expect, the more comprehensive the program, the more funding sources identified, although both Oakland and Knoxville appear to be exceptions. (In Oakland, as the case description indicates, there have been many program initiatives, but there has been difficulty sustaining them and linking them into a comprehensive service network. In Knoxville, several of the funding sources were earmarked for

Table 6-1

Historical and Current Sources of Funds for Local Program Support by Locality, 1970-1981**

Source	"Comprehensive" Sites					"Non-Comprehensive" Sites				
Federal*	Chatt.	Pitt Co.	Fresno	Kal.	Worc.	Knox.	S.M.	Oak.	Sag.	Lowell
Title XIX (Medicaid)	X	X	X	X	X	X	X	X	X	X
Title XX	X		X	X	X				X	
Title I, ESEA						X				
Title II, ESEA (innovative)				X	X			X	X	
PL 94-142 Sp. Ed.	X					X				
Job Training Partnership Aid						X				
Jobs Bill Countercyclical Aid					X					
Office of Adol. Preg. Programs		X						X		
Head Start			X							X
PL 94-482 Voc. Ed.										
Comm. Services Administration					X					
CETA					X	X				
MCH Block Grant	X			X						
LEAA	X				X					
Title X, Family Planning					X					
Model Cities										
State*										
Michigan: PA242					X					
State MOdel Sites					X					
Improved Preg.					X					
Tennessee:						X				
Perinatal Proj.							X	X		
California: PMP		X		X						
SAPID		X		X						
Parenting				X						
Mass: DSS						X				X
DMH						X				
DPH										
City/County							X	X		
School District	X			X	X	X				
Revenue Sharing				X	X					
Local/Voluntary									X	
Mott Foundation					X		X			
March of Dimes					X	X				X
United Way	X			X	X	X	X		X	
Local Foundations	X				X	X	X			
Other (includes Churches, JL, etc.)	X	X			X	X	X			

*Programs listed under Federal and State categories may include a combination of Federal and State funds.

**Only the Worcester, Oakland, and Kalamazoo programs span this entire time period.

the Rule High School Program, just getting underway at the time of the site visit.)

Flexibility. Perhaps even more important than the number and variety of funding sources is their flexibility, or the lack thereof. In general, the federal and state funds come with more or less precise regulations limiting their use. While this may improve accountability, the resultant limitations impede the use of these funds for developing comprehensive services. None of the special purpose grants cover the full range of component services and related program needs. Consequently, the more successful programs are those that can also draw upon more flexible, generally local, funds. These include United Way, local foundation, and city and revenue sharing dollars as well as a variety of cash, volunteer, and in-kind contributions from local charitable organizations.

Funding limitations. Another major limitation of many of the funding sources is their lack of reliability. Several of the funding sources cited as important at earlier times, including Model Cities, LEAA, CSA, and CETA no longer exist. Jobs Bill funds were a temporary, one time counter-cyclical allocation to state maternal and child health agencies in 1982 used by some states for services related to adolescent pregnancy. Other sources, like Title 1, Elementary and Secondary Education Act, Vocational Education Act, Head-start, and special education funds are not intended primarily for adolescent pregnancy programs; it requires considerable ingenuity on the part of local administrators to fit them into a coherent package of support. In fact, in the case of special education funds, the federal law, PL 94-142, the Education for All Handicapped Children Act of 1975, explicitly excludes pregnancy as a condition eligible for support.

Foundation funding was invariably of limited duration. Aside from such temporary sources, there is little basic ongoing program support. This underscores the importance of special earmarked program funds like those available in Michigan, Massachusetts, and in California, as well as federal Office of Adolescent Family life (formerly Office of Adolescent Pregnancy Programs) grants. The federal aid, while important for those few programs receiving it, is grossly inadequate in relation to the need. The state programs are in jeopardy and appropriations are insufficient for expansion beyond the fortunate few localities currently being assisted.

Civic Culture

We were struck by the sharp contrasts between the matched pairs in our sample with respect to local community support for helping pregnant and parenting teenagers. In this country, adolescent pregnancy, at least among white teenagers, has long been considered a fitting subject for rescue work carried out by religious and non-sectarian charities. In certain of our study sites, we find this local service tradition still flourishing; this is a distinguishing feature of the more successful programs, particularly those in Kalamazoo, Chattanooga, and Worcester.

We noted important differences among the sites in elite support and sanction for adolescent pregnancy programs. Our respondents readily related the presence or absence of such support to local traditions and community ethos.

The supportive community ethos. The distinguishing characteristics of a supportive community ethos included: a strong service ethic that holds that the community should and will somehow solve its problems; involvement in charitable work by local elites including members of wealthy old families whose financial and sometimes personal support demonstrated a sense of noblesse oblige; a cadre of volunteers, many of them from affluent families; and heavily-endowed and well-supported local charitable foundations and strong United Way organizations.

These characteristics especially stand out in the comparisons of the matched localities in Massachusetts, Tennessee, and Michigan. The contrasts are less apparent in the California sites, but some differences were noted, particularly between Elk Grove and Santa Maria. An early history of the Crittenton Mission states that the work of the Lowell Crittenton Rescue League "was called forth by the evil conditions which prevailed.... A large percentage of the people were of foreign birth... and the influence of their Continental ways of living was highly demoralizing on the native American population."[2] The account goes on to document difficulties in sustaining services over the years (1905-1933), a story much the same as we heard some 50 years later. Today, Lowell is still characterized by some as "an immigrant town" with severe economic problems and poor schools and social services. Its new high tech industrial leaders are described by some Hispanic leaders as "the new oppressors" whose charitable efforts result in little "trickle down" to the poor. In contrast, Worcester has strong philanthropic roots. It was the site of the nation's first

mental hospital, regarded at the time (and at various other times in its long history) as a progressive, innovative institution. The Massachusetts Society for the Prevention of Cruelty to Children has a strong presence in Worcester, and was one of the first of its kind in the nation and one of the few remaining survivors of an earlier charitable tradition. There are some 200-250 social service agencies, and a very strong United Way organization in Worcester. Many of our respondents spoke with obvious pride about the local tradition of social service innovation.

Kalamazoo has a long history of social welfare activism by local wealthy families. Four or five prominent families are said to be involved in most social issues. The city boasts a number of progressive civic innovations. It was the first of its size to adopt a city manager form of government, build a downtown pedestrian mall, and support a symphony and art center. As one respondent stated, echoing sentiments we heard again and again, "This is a town with social conscience." Saginaw lacks both this tradition and the cadre of affluent families to carry it out.

Chattanooga, the beneficiary of Coca Cola wealth, has more local foundation money than the rest of the state of Tennessee combined. Its United Way has never missed a campaign goal in its 56 years of existence; and its Allied Arts council raised the third highest amount per capita in the nation. The contrast with Knoxville is "like light and darkness," in the words of one respondent. Knoxville, while not lacking in wealthy individuals, was said to be in the firm control of "four or five powerful men...(who) run the town for their own benefit." The remains of the Worlds Fair, a substantial financial loss to the community, dominate the downtown area in testimony to this assessment.

Volunteer service. One material manifestation of civic culture is a commitment to volunteer service. Volunteer service was by no means limited to affluent individuals. In several instances, nurses, social workers, and other staff had started in programs as volunteers, later moving into paid staff positions. In at least one case, paid staff were reduced to volunteer status because of interruptions in funding.

But if volunteer effort is not the exclusive domain of the leisure classes, there is no doubt that affluence helps. A number of volunteers we encountered fit within what is becoming a rare category, the full-time homemaker supported by her spouse. In Santa Maria, for example, we were told that the wives of successful professional men "are not allowed

to work," so that at least some are available for volunteer service. In fact in several sites the local Junior League played a major role in service development. One League member who had been recruited to a staff position after years of volunteer service explained, "I don't need this job. We have a swimming pool in the back yard, I drive a Lincoln Continental, and my husband drives a Mercedes." Such volunteer resources are limited and becoming progressively more scarce. For example one Junior League, described as "a couple hundred strong," had only "eight to ten people we can count on for hands-on organizing." As one long-time volunteer explained:

> "I guess I'm an idealist. I hope I've raised a spark somewhere along the line and had an impact on somebody. I laugh when I hear somebody like Reagan say something about voluntarism. Somebody is kidding somebody if they think voluntarism is going to save this country. I think I'm a dying breed. The younger people aren't doing it anymore. I found that by...1970 we just couldn't get volunteers anymore...people just can't be committed the way they once were. That's not because they care any less, but there's a difference in the need that people have financially. They need two incomes now of course."

Another constraint on the use of volunteers is the lack of staff to oversee their activities. An Oakland administrator put it bluntly. "We don't have volunteers because there aren't staff available here to supervise them." A major state Department of Health Services "family communication program" piloted in one of the study sites in 1981 failed largely because of its overreliance on volunteer effort. As one informant explained, "Unless you get people besides volunteers working, it won't make it through. You need some back up from professionals." Another, speaking of Governor Deukmejian's administration emphasis said, "These guys think you can just let the community take care of all the problems. Everything will get done by voluntarism. The whole Health and Welfare Agency has a philosophy that is permeated by this type of approach. They're out of another century."

Coordination

While much can be done to improve service coordination in any community, there are several preconditions that determine how easy and effective such efforts may be. We

found that resources, including staff and money; some official, authoritative sanction for coordination; and mechanisms for accommodating ideological differences were essential. In addition the possibility of federal (OAPP/OAFL) or state funding conditioned upon coordinated services provided strong incentives for interagency cooperation.

Such incentives and resources could be created in the short run to encourage and facilitate coordination and cooperation. At the same time, in those localities and situations where coordination was most successfully accomplished, we observed several pre-existing conditions that appeared to be a more or less permanent feature of the service environment. These included:

a service climate supportive of community planning;

a history of successful planning and coordinating efforts;

an experienced cadre of agency administrators and representatives who knew each other well;

a relative stability of organizations and workers;

physical proximity of the coordinating organizations; and

a strong authoritative coordinating body or mechanism such as United Way or community planning cooperation.

The same kinds of strategies that worked best in such a supportive environment, had difficulty taking hold in the absence of these favorable conditions. In the discussion below, we begin with an elaboration of the conditions found to facilitate coordination, and we then examine successful strategies.

A tradition of interagency coordination. In those localities where coordination of services for pregnant and parenting adolescents was most successful--Fresno, Kalamazoo, Elk Grove, Worcester, Chattanooga, and to a somewhat lesser extent, Oakland--we found a history of prior successful coordinating activities. In other localities, particularly Lowell, Knoxville, Saginaw, and Santa Maria, such a supportive tradition was notably lacking. The manifestations of this tradition were prior successful coordinating activities in which the agencies had taken part; and a group of individuals including administrators, workers, and volunteers who knew each other well, saw one another

often, and expected to work together to accomplish shared goals, despite sometimes very sharp ideological and other differences. One respondent in Fresno, referring to the REAP Congress of 57 agencies involved with teenage parents told us, "We all know each other very well--We live right here in town." In Oakland, we were told, "The sophisticated agencies work together...People are not into turf here. There's a philosophy of networking and sharing resources." And, "People know each other and work well together." These personal ties are reinforced by physical proximity, a relatively low turnover of staff and administrators, and numerous day to day opportunities to work and meet together on various community issues.

A facilitating mechanism is one borrowed from the business community: the practice of having interlocking agency boards. This was particularly pronounced in Kalamazoo and Chattanooga. As one Chattanooga administrator described it, "There are close community ties among the various boards and persons...lots of cross-pollination, crossing of lines...Fifty percent of those on my board are on other boards." Of course, close ties do not guarantee cooperation. In one of our sites, a key administrator was described as difficult to work with. This administrator summed up her philosophy about coordination, "If you can control the service, do it. Don't worry about duplication."

Coordinating mechanisms. A key element in facilitating coordination was some external, authoritative body that had official responsibility for it, as well as sanction from the agencies to be coordinated. Often the local United Way or a public/private planning offshoot like the Fresno Community Council, the Chattanooga Metropolitan Council for Community Services, or the Worcester Social Services Cooperation, provides the resources and sanction for coordination. This sanction, it should be noted, comes from a body that also controls essential resources. The United Ways fund many of the agencies comprising the service network for teenage parents, and the community corporations have an important role in the local allocation of public funds as well. As one veteran of many coordination efforts explained, "You need political clout to get these things going. You can't do it by routine community organization. You have to know who has the power. You need permanence."

United Ways and United Way-supported planning organizations were not the only coordinating mechanisms we encountered. In Fresno, the highly effective Interagency Council had the benefit of full-time professional and

secretarial staff support backed by the authority of the juvenile court judge. Oakland's Reproductive Health and Family Planning Forum served as a coordinating body for its constituent members for ten years before losing its funding in 1983.

The absence of official authoritative sanction undermined several coordinating efforts. In Knoxville, an informal task force met for several years in the mid-1970's, but fell apart because participants "never had anything to say." The group lacked a formal structure and staff support, and was never officially endorsed by the directors of the constituent agencies. A like fate befell a state level interagency task force in California. According to one participant, the effort failed "due to the chronic problem of not getting higher level bureaucrats to sign off. We never got above mid-level bureaucrats." Governor Brown could not be convinced to lend support, financial or otherwise. He was reported to have dismissed the effort, saying about coordination, "It doesn't sing, it's boring," a sentiment possibly reflecting the potential political appeal of such efforts.

An essential coordinating function is the bridging of ideological differences and competition for clients and funds among service providers. In several instances, agencies actively sought to prevent others from receiving funds; in other cases, agencies refused to refer clients or otherwise cooperate with other organizations. The less than enthusiastic reception of the OAPP-funded Appalachian Adolescent Health and Education Project (AAHEP) among Knoxville service providers was explained as being due to AAHEP's ideological perspective, and lack of trained staff and services. Critical reactions from various professionals included the following comments: "Knoxville has the services they would be providing." "They have a totally untrained staff." "They're trying to get teens not to have sex." "They're trying to teach them to be chaste. Good luck!"

Even more contentious are issues that divide agencies with respect to abortion, family planning, or relinquishment for adoption. In those localities where coordination was most successful, some accommodation had been reached to enable ideological antagonists to cooperate. In both Michigan and Tennessee, state level efforts to promote family life education in public schools benefited from the inclusion of right-to-life organizations and their opponents within the planning bodies. In Worcester, it is generally understood that Catholic Family Services, while supportive of services, can only participate in cooperative efforts as long as they are free to promulgate

their pro-life position and not be associated with any pro-choice services.

Finally, the prospect of receiving support conditioned upon cooperative and collaborative effort can provide a strong incentive for interagency cooperation. This was the case with the OAPP ACCESS application in Worcester and with programs funded under special state grants in Michigan and Massachusetts. On the other hand, the failure of such collaborative grant application efforts can leave a residue of ill feeling. A group of Oakland service providers were said to be embittered when, after protracted negotiations with OAPP, their application was denied. With so many applicants for so few grants, the waste of time, effort, and other resources can be very costly.

STRATEGIES TO PROMOTE AND MAINTAIN SERVICES

As discussed earlier, a number of conditions can facilitate the development and maintenance of services. Many of these are community characteristics which cannot be altered through outside intervention, at least in the short run. Several kinds of strategies, however, can be used to build support and deflect opposition. While these can be used in any community, the more successful localities have the requisite personal, financial, and other implementing resources.

We found two somewhat contradictory kinds of strategies used concurrently in most of the localities we studied. On the one hand, service advocates sought to gain legitimacy and support for unpopular and stigmatized services and clientele by recruiting elite supporters, through lobbying and public relations, and by associating adolescent pregnancy with other issues of public and political concern. On the other hand, advocates also sought to avoid opposition by keeping the programs out of public view. Walking this kind of tightrope severely tested the ingenuity and political skills of the service advocates.

Service providers also faced another kind of test of their administrative skills. As shown below, many agencies had to make drastic changes in mission, goals, and clientele in order to adapt to a rapidly changing service environment. Those that failed to make such adjustments faced extinction. However, in some instances, the successes demonstrate an

uneasy tension between organizational needs and the interests of the client population.

Securing Elite Support

The nature of adolescent pregnancy and the male dominance of the interventive service institutions require the recruitment and sensitizing of male gatekeepers for services to be developed and maintained. For most of the women we interviewed, their interest in the issue came about through personal experience, generally in their work roles, but, in some instances, in the early pregnancy of friends, family members, or in some cases, themselves. One prominent advocate, described as being "on the radical fringe" because of her outspoken advocacy, was a former teen parent. Another activist explained that her sister had been an unwed mother and welfare recipient at age 16. She herself had married at 18 and had her first child at 19. A staff worker, described as particularly effective, started as a client with the program for which she now worked. We did not systematically seek such revelations; but they were volunteered with such frequency that we suspect personal involvement was common to many.

More frequent still was the introduction to the issue by way of work roles, both paid and volunteer. This is not surprising given the fact that so many of the women working in the programs had started in traditionally female occupations--nursing, social work, home economics, and teaching, for example. These same occupations are also the ones from which the staff workers for the programs are drawn. The gender-based division of labor is illustrated by the following incident that occurred shortly before our visit to one of the sites. The director of this school-based program was due to be "bumped"--i.e., replaced by someone with greater seniority and moved to a lower level job--as part of a general retrenchment. However, all of those in line for her job were men. Somehow, the school administration found a way at the last minute to retain her, because without her, they faced having to terminate the program. She posed the administration's dilemma, "Can you see a man coming in and doing this?" (In fact, we found only one man directing a local adolescent pregnancy program in the course of the study.)

It should be noted that this rather strict division of labor may inhibit the involvement of male teenagers in programs. In one of the few instances where we found effective outreach to males, it was due to the work of a male

staff member. In another instance, the local sheriff, "a prototypical law enforcement man," after participating in an interagency committee, initiated a sex education program for boys incarcerated in the juvenile detention center.

If women in general are socialized to be favorably disposed toward helping pregnant and parenting adolescents, men definitely are not. The task for program advocates is one of converting influential males to adopting a supportive attitude. This is particularly important because of the gender-based division of labor. Males, with few exceptions, are the gatekeepers who control the funds, service institutions and policy-making bodies on which programs depend.

Converting Male Gatekeepers

Sometimes increased awareness occurs through family relationships. One male activist reported that his sensitivity to the issue began with his mother's involvement on the Planned Parenthood Association board. An influential school board member became interested because of his wife's work. One of the more notable conversions was that of Tennessee Governor Lamar Alexander, who has made children's services a focus of his administration. His wife, Honey Alexander, told us that her own interest in adolescent pregnancy began with her involvement about 14 years ago as a Planned Parenthood volunteer. This sparked her concern about "kids having kids," but it was only recently that her husband has come to recognize the importance of the issue. Such conversions do not always have positive consequences for the development of services, however. In one instance, school involvement in the development of a comprehensive service was blocked by key administrators whose wives were officials of the local right-to-life organization and opposed any involvement with a family planning agency.

Legislative support is crucial for the passage of pertinent laws and appropriations. Most often, the interested and influential legislators were males, but almost invariably, they had women staff assistants whose concern about adolescent pregnancy was apparently a significant factor in their advocacy.

The conversion process is illustrated by the following account. In one of the study sites, a model cities worker had conducted a needs assessment that showed "unwed mothers" to be "a big problem." She and a colleague

convinced a coalition of women professionals to address the issue. Original members included the only woman in the school administration, a public health nurse, representatives of the Visiting Nurse Association and the YWCA. Later, one of these women met with a group of local pediatricians, predominantly male, who had started convening to discuss adolescent health issues. As our informant observed, "their practices weren't exactly booming. They were talking about drugs, acne and so on. I said, 'what about pregnancy?' The problem captured their imagination...and became the group's focal point."

Women are of course increasingly exerting leadership in their own right. Massachusetts' adolescent pregnancy initiative was proposed and sold to a recalcitrant legislature by Mary Jane England, then Commissioner of the Department of Social Services. With her departure following the election of Governor Dukakis, the future of this program remains in doubt. In several of our study sites, the Junior League has been instrumental in initiating and supporting services, especially family life education, often overcoming the reluctance of school administrators. One admirer of such efforts confessed to having had a negative view of the League. "Some of the best people are from the Junior League. I was amazed. I always thought the Junior League just threw parties...The women are getting stronger and more assertive. They don't defer to men so much."

The Politics of Program Support

Program proponents tread cautiously in seeking support because of the stigma attached to the clients, services, and service providers, and the ability of a vocal minority to block the development of services. There are a number of strategies and techniques used to avoid controversy and gain support for services for pregnant and parenting adolescents. The specific strategies vary from place to place depending on the local situation. The political climate is somewhat more accommodating in some places than others. But we found virtually all of the following approaches used in one or another combination in all the study sites. In general the strategies involved efforts to broaden the appeal of the services and programs, secure strong and prominent allies, and at the same time, conceal aspects of the services that might draw fire from opponents.

Broadening the appeal. Service advocates and providers used several complementary techniques in their efforts to

broaden the base of support for their programs. They sought to mute the opposition by meeting their concerns, either by modifying aspects of the services that the potential opposition might find offensive, or by appearing to do so. They also sought to tie adolescent pregnancy to other less stigmatized issues, like the reduction of infant mortality, child abuse, and mental retardation. Wherever possible, they dramatized the need for such services and sought to demonstrate their relative cost effectiveness.

The attempts of administrators to avoid opposition sometimes seriously compromised the services. For example, Planned Parenthood organizations in many communities were excluded from United Way campaigns and often from overt participation in service networks. In Oakland, service providers who were leading the fight for restoration of state health funds were prepared to delete family planning in order to secure the two-thirds majority necessary to override the Governor's veto. Right-to-life advocates had successfully argued that family planning funds were really "abortion funds," although none of the funds did in fact support abortion. In one study site, a compromise over family life education resulted in its being limited to 12th graders. Programs for pregnant students were often limited to those in secondary school or over the age of 15. In general, programs tended to limit family planning services, avoid abortion, and provide sex education only for the already pregnant, or sharply limit the content and coverage.

Some of the accommodations to potential opponents are more symbolic than real. One service proponent was said to "talk like a conservative so that he's acceptable to a broad-based constituency." Sex education is rarely referred to as that; it is family life education. The Knoxville family life education program, operated under the protective cloak of the local Junior League, was called the Teen Awareness Program. One influential administrator described how he was able to sway conservative school board members to accept a school-based program by understanding their concerns and reservations and, in essence, speaking the same language.

Medicalization. Another common way to legitimize services for pregnant and parenting adolescents was to emphasize their medical aspects. This was accomplished in several ways. One was simply to stress in program descriptions the medical program components, generally in ways that focus on maternal and child health rather than family planning. Another was to find advocates in the medical community. This permitted the issue to be posed as one

requiring the intervention of medical experts, a disease to be contained and cured, instead of the less appealing problem of helping "bad girls." Several programs were introduced by school board members who also happened to be physicians. Such individuals satisfied several criteria for effective local advocacy: social prominence, medical expertise, and being of the correct gender, male. Often, program tasks that might provoke controversy were delegated to nurses. In the words of one school administrator, "Our policy is if it's a medical or a taboo subject, let the nurses do it."

Programmatic Coattails. A popular strategy almost universally employed was to associate adolescent pregnancy with other issues that were less controversial, that engendered greater public and political support or that might yield funding. Few agencies focus on adolescent pregnancy as their exclusive concern. It is essential, therefore, in building local service and advocacy networks that the constituent organizations be able to define an emphasis on adolescent pregnancy as consistent with their own goals and missions, such as preventing school dropouts, ending welfare dependency, promoting maternal and infant health, and preventing child abuse.

We encountered an incredible array of problems that allegedly would be solved by the provision of services for pregnant and parenting adolescents. Reminiscent of claims for the patent medicine nostrums of the last century, teenage pregnancy services were variously advocated to combat child abuse, crime, youth unemployment, sexual abuse, infant mortality, mental retardation, birth defects, the feminization of poverty, drug abuse, welfare dependency, and poor nutrition. A common theme underlying this approach is summed up in the words of one program manager: "...present it every way but sexual."

The coattails strategy serves at least three complementary functions for program advocates. It can potentially broaden the base of support by encompassing a larger number of issues. It may also diminish the stigma attached to adolescent pregnancy and sexuality by associating it with more legitimized concerns. And finally, the association of adolescent pregnancy with other identified problems provides a rationale for tapping funding sources available for other issues.

We found this strategy widely employed at both state and local levels. One notable example at the state level is the passage of Massachusetts' Services to Young Parents

Initiative. One informant involved in lobbying for the initiative described the task in these terms: "Most legislators respond to it on a purely personal level, in terms of their own kids. They feel 'bad girls' should be punished, that they might contaminate the others, and so on." Consequently, the Initiative, which had failed in two successive tries, had to be sold as central to the major mission of the Department of Social Services, the prevention of child abuse, and of the legislature's interest in reducing AFDC rolls. A key to this strategy was to make it clear that the money was not for prevention--especially family planning or abortion, although Massachusetts is among those states that continues to fund abortions for Medicaid recipients (under court order). The emphasis in the Initiative was on services to the already pregnant and/or parenting with the clear implication that such services would help prevent child abuse and lower welfare dependency.[2]

The strategy of focusing on the children is widely employed at the local level as well. In one community, for example, photos of babies were said to have "turned the tide" in favor of support for services. As an advocate explained, in his conservative community, "They believe in taking care of children right; they just don't like to admit where the children came from or why." In a like manner, the association of adolescent pregnancy with a host of other issues at the local level can activate a broader base of support and diffuse potential opposition.

Concealment. Closely related to the coattails strategy is that of concealment. While it takes many forms, the common element is that of "keeping a low profile," as we were told again and again. We have already noted the tendency to find names for programs and services that stress the positive aspects and skirt controversial issues--teen awareness, family life education, ACCESS, Services to Young Parents, Healthworks, Project Redirection, Teen Parent Family Support Project, and Continuing Education to Young Families, for example. In one instance, that of the California CYESIS programs, the generic name used by a number of local programs is literally Greek. (It means pregnancy). A number of respondents confirmed that the obscurity of the term was its primary appeal. "Cyesis was picked because nobody really knew what it meant."

In addition to the semantic concealment, programs are often located out of sight. Churches are particularly popular, because of the availability of underutilized Sunday School classroom space, and perhaps the traditional religious

interest in rescue work. For school-based programs, "keeping a low profile" often means location in separate facilities away from the regular school environment, in alternative adult education or vocational schools, in self-contained units off-campus, or in surplus school buildings. While this is sometimes explained by school administrators as necessary to "protect" the young women, few if any of the service providers really believe this. They are emphatic that the hiding away of programs permits school officials to get rid of the offending women, while "checking off" the problem as being taken care of. As one administrator explained, "The alternative centers are not closely paid attention to. They're for kids who've been kicked out." Programs operating within regular school settings are generally "kept quiet" to avoid arousing opposition. We encountered one program known to very few others in or out of the school administration because of the successful efforts of its sponsors to keep it hidden.

Another aspect of the concealment strategy is to limit the recruitment of clients to those methods that avoid publicizing the services to a wide audience. Probably the most utilized and effective outreach and recruitment method is through the clients themselves. Word-of-mouth was the most frequently mentioned source of new clients. Aside from such informal means, recruitment is generally carried out through professional and organizational networks where it can be done quietly.

The strategy of concealment even extends to legislative advocacy. At the state level, particularly in Massachusetts and Michigan, advocates sought to avoid calling attention to prior legislative gains for fear of losing ground in subsequent legislative action.

Lobbying

Obviously, if programs were too successful in concealing their goals and activities, they would have neither clients nor funds. Some measure of lobbying at the state and local levels is necessary to secure support and acceptance for the services. This is not always done with as much circumspection as the previous discussion would suggest. In localities with a somewhat progressive service climate, advocates use every possible means to publicize the need for services and portray them in a positive light. Oakland effectively exploited its unusually high infant morality rate in order to secure state, federal and private funds. Worcester

providers held frequent breakfast meetings with area legislators. The Elk Grove program has gained national prominence through visits and favorable comment by former Senator Hayakawa. In a similar vein, the Kalamazoo program benefited from visits from the state Superintendent of Education and identification as a model program.

In general, the local media were reported to be helpful in publicizing services when asked to do so, and fair in their news coverage. Lobbying was most visible when tied to other related issues like infant mortality and maternal and child health. Otherwise, lobbying for adolescent pregnancy services tended to be carried out more quietly. A number of program managers used their advisory boards to forge supportive links with influential persons in the community. More commonly, these personal lobbying efforts were carried out informally. In at least one case, familiarity with the personal lives of potential opponents was used to deflect their opposition. This is illustrated in the following account:

> "This community is exceptionally hypocritical. They have values...however, their behavior is quite another story. One of the things I've been able to do because I've stayed in the community for so long is to hold my knowledge of people's actions over them when they try to get too high and mighty."

We mentioned earlier the general lack of emphasis on program evaluation. Concern about program statistics was raised in two rather specific contexts. First, attendance statistics are a crucial means by which school-based programs justify their existence. By keeping students in school, such programs bring in funds based on average daily attendance (ADA), and they use this income-generating capacity to argue for continued support. Second, most of those who work with the state legislatures stress the need for statistics justifying the services in order to sell them to potential legislative supporters. The relative lack of evaluative data hampered the effectiveness of lobbying.

Conclusion

The comparison of comprehensive and non-comprehensive sites revealed a number of community characteristics and resources that facilitated the development and maintenance of services for pregnant and parenting adolescents. We identified leadership, the capacity to secure support from multiple sources, a civic culture supportive of charitable endeavors,

and a strong voluntary sector as particularly crucial. Also significant was the tradition of interagency cooperation and coordination that prevailed in the comprehensive sites. With the possible exception of coordination, these resources are not easily developed by public policy initiatives, at least in the short run.

The study also identified a number of common strategies for developing and maintaining services. Local elites, including males who controlled access to resources, were recruited as advocates, and the problem was defined in such a way as to broaden its appeal and diminish the stigma. Frequently, advocates sought to avoid public attention so as not to attract opposition. As we discuss in the concluding chapter, those localities that are more advantaged in the sense of having the resources that facilitate program development are not necessarily the ones that need such services the most. Public policy that fails to take into account the major differences in local capacity only perpetuates the unevenness in service availability that now prevails.

NOTES

1. For a summary of the pertinent research, see Victor H. Vroom. Leadership. In Marvin D. Dunette (Ed.), Handbook of industrial and organizational psychology. Chicago, IL: Rand McNally College Publishing Co., 1975, pp. 1527-51.

2. For an account of the Massachusetts Legislature's recent activities with respect to reproductive issues, see Virginia G. Cartoof. Massachusetts' Parental Consent Law: Origins, implementation, and impact. A dissertation presented to the faculty of the Florence Heller Graduate School, Brandeis University, 1984, esp. Ch. 4, Legislative intent, pp. 83-112.

Chapter 9. Patchwork Programs and Public Policy: Conclusions and Recommendations

The findings of this study are cause for both optimism and concern. The programs we observed stand as a testimony to the vibrancy, resourcefulness, and responsiveness of local effort. The development and survival of local programs during the past decade is nothing less than phenomenal considering the obstacles and relative scarcity of resources. The case studies demonstrate how much can be done with few resources. We have seen programs fashioned out of bits and pieces of diverse services, borrowed and volunteer personnel, loaned space, donated materials, voluntary contributions, and various federal, state, and local grants. The pragmatism and ingenuity of program advocates fits the tradition of the American patchwork quilt. But we must ask, is the encouragement of a cottage industry an appropriate response to what is considered a serious, widespread social problem?

Local effort, supported by public and private funding, has brought about a number of exemplary programs and excellent services. But these are exceptional, and for reasons we will elaborate below, must inevitably remain so in the absence of basic policy changes. Program failures, while less publicized, are perhaps a more significant gauge of public policies with respect to adolescent sexuality. This study found numerous situations in which charitable intent, hard work, administrative and political skill have proven insufficient to breach the barriers to service development. That so much effort should produce so little in the way of results is indicative of the inefficiency of current approaches.

In this concluding chapter, we summarize the principal findings of the study and offer policy recommendations. We begin with an assessment of the comprehensive services model and the constraints to its local implementation. We then summarize the local conditions associated with successful program development and the various strategies used to circumvent or overcome the constraints. This discussion underscores the importance of state and federal resources. It also points to a bias in the utilization of these resources that favors the development of services in relatively few fortunate localities. We conclude with a range of policy recommendations that would lead to a more equitable and effective use of resources.

THE LIMITS OF COMPREHENSIVENESS

In policy discussions about comprehensive services, the categories, "comprehensive" and "non-comprehensive" are often treated as if they were empirically as well as conceptually distinct. We maintained the conceptual distinction for the purpose of conducting a comparative study. However, it is important to underscore this fact: the programs we studied differed in degree more than in kind. Comprehensiveness is relative; all programs fall short of the ideal in some respects.

In Chapter 2 we examined several alternative definitions of comprehensiveness (summarized in Table 2-1). The most expansive definitions include a wide range of discrete services to be offered in the pre and postnatal periods. In reality, even the very best programs are limited in the following ways:

a. numbers served. Because of the lack of pertinent statistical data, it is difficult to assess the relative penetration rates achieved by the various programs and service components. As far as we could determine, even the most highly developed ancillary services reach only a portion of those presumed to need them. The necessity for programs to keep a low profile, and the absence of essential service components that facilitate recruitment--transportation, day care and agressive outreach--may limit participation to the most highly motivated. Most programs also have explicit eligibility requirements that further restrict participation to those of a particular age, stage of pregnancy or parenthood, grade level, or school enrollment status.

Tables 9-1, 9-2, and 9-3, give a breakdown of the numbers served in each of the study sites by program function. Not all adolescent parents need to be in special programs. On the other hand, birth statistics alone may substantially underestimate the need for services as they do not reflect those who are pregnant and do not carry to term or, most importantly, those with infants and young children who may continue to need services. A strong case can be made that the need for services increases after delivery. Yet many, perhaps most, programs provide services only up until delivery, or for a very short period thereafter. Whatever the exact size of the pool of potential clientele, it is clear that even the largest programs reach only a limited proportion.

Table 9-1

Special Services for Pregnant/Parenting Adolescents:
Numbers Served: California Sites

LOCALITIES:	FRESNO*	OAKLAND	ELK GROVE*	SANTA MARIA
EDUCATION:				
Toward H.S. Grad.	289	300?	150?	68
Health Education	289	250	150?	68
HEALTH CARE:				
Prenatal care	20/month	400?	75	0
Family planning	0	400?	0	0
SOCIAL SERVICES:				
Group counseling	75/month?	0	150?	0
Individual couns.	75/month?	as needed	75?	0
Adoption	75/month?	" "	0	0
Abortion Counseling	75/month?	" "	80	0
DAY CARE:	225	50?	80	0
VOCATIONAL ED/ JOB TRAINING	some	100?	0	0
TRANSPORTATION	289	Passes/ Pub. trans.	150?	0
Births to Women under 20	1,056(1978)	1,015(1978)	N/A	163 (under 19, 1982)

*Locality with comprehensive services.
SOURCE OF DATA: All data were provided by state health officials, program administrators or service providers from the programs themselves.
NOTES: Unless otherwise indicated, numbers represent those seen over the course of a year, either calendar 1983, or a 12-month period including part of 1982 and 1983. ? indicates an approximate number. "As needed" indicates that a serivce is potentially available to the number of clients cited, but is only provided on request, or when it is judged necessary by staff.

Table 9-2

Special Services for Pregnant/Parenting Adolescents:
Numbers Served: Massachusetts and Michigan Sites

LOCALITIES:	WORCESTER*	LOWELL	KALAMAZOO*	SAGINAW
EDUCATION:				
Toward H.S. Grad.	70-80	0	179	0
Health Education	70-80	0	179	168
HEALTH CARE:				
Prenatal care	150-200	0	30/week	120/MIC Program
Family planning	400?	150	0	0
SOCIAL SERVICES:				
Group counseling	130?	20?	10/week	0
Individual couns.	200?	30?	179	0
Adoption	170?	0	179 as needed	0
Abortion Counseling	200 as needed	150 as needed	179 as needed	0
DAY CARE:	10 slots rotated for 30-40 babies	0	124	20
VOCATIONAL ED/ JOB TRAINING	0	0	0	0
TRANSPORTATION	To med. appts. only	0	179	Passes for pub. trans.
Births to Women under 20	370(1980)	304(1980)	202(1982)	349 (1982)

*Locality with comprehensive services.
For source of data and informational notes, see Table 9-1.

Table 9-3

Special Services for Pregnant/Parenting Adolescents:
Numbers Served per Year: Tennessee Sites

LOCALITIES:	CHATTANOOGA*		KNOXVILLE
EDUCATION:			
Toward H.S. Grad.	80		7
Health Education	80		0
HEALTH CARE:			
Prenatal care	0		0
Family planning	0		0
SOCIAL SERVICES:			
Group counseling	80]	as	10
Individual couns.	80]	needed	0
Adoption	80]		0
Abortion Counseling	0		0
DAY CARE:	0		15
VOCATIONAL ED/ JOB TRAINING	0		0
TRANSPORTATION	0		0
Births to Women under 20	531(1982)		439(1982)

*Locality with comprehensive services.
For source of data and informational notes, see Table 9-1.

b. number and type of discrete services. For most programs, the services available are limited to little more than coordinating what the community already has available. Where financial aid, medical care, housing assistance, day care, and vocational training are inadequate, the best programs can do little to overcome these deficits. The comprehensive services model presupposes a range of basic health and welfare programs and services which, alone among industrial nations, the United States does not have. Consequently the programs are best at what they do with few resources: provide sympathetic adult support in a nurturing environment and help with referral to whatever services the community has to offer. Social and political constraints limit services to those aimed at helping the adolescents after they have become pregnant; very little is being done by way of prevention. The programs generally focus on a brief time span, usually from the second trimester of pregnancy through three months postpartum--less than one year. Services are offered in the mode of crisis intervention: short-term, time-limited, with little or no follow-up. One should not be misled that this somehow constitutes a solution to the problem of adolescent pregnancy.

c. geographical coverage. The distribution of programs and services across the country and within states bears little relation to the need as we found in developing a sample frame. For example, some states, like Massachusetts, have among the most highly developed services and lowest adolescent fertility rates. Other states, most notably those with the lowest per capita incomes and least resources, have high fertility rates and few services. In more than half the sites we visited, service provision was arbitrarily restricted to within jurisdictional (i.e., municipal, county, or school district) boundaries. Those residing outside such boundaries often had no alternative programs available. This situation seems likely to get worse with further federal program cuts being contemplated.

CONSTRAINTS TO PROGRAM DEVELOPMENT

As shown in Chapter 7, program developers and advocates face formidable obstacles to their efforts. Developing and coordinating services in an interorganizational setting is among the most difficult of managerial tasks. It requires staff time and organizational resources that are often lacking. It presupposes a commonality of organizational purpose that may not exist. It calls for an array of services that may not be in place. The policy prescriptions suggested by various

program models or solicitations for proposals do not always take sufficient note of these difficulties. Nor do they address what are perhaps an even more formidable set of obstacles, namely the political and attitudinal constraints. The normal channels of political and administrative reform are of limited utility because of the stigma attached to the programs and clients, the male control of institutions assigned to deal with this "female" problem, and the ability of vociferous minorities to veto efforts they view as encouraging premarital sexuality. Furthermore, while the programs seem intuitively to be humane and valid, the effectiveness of many of the interventive techniques has yet to be demonstrated. On the other hand, there is clear evidence that many of the problematic conditions associated with adolescent pregnancy originate in poverty. Intervention to address that more basic problem still awaits implementation.

The constraints insure that under present conditions, few new programs will be developed; those that are will be limited in scope and coverage. The disjuncture between what is desirable and what is possible is illustrated by the quest for school-based services. A school-based model has considerable intuitive appeal, largely because of the accessibility of at least a large portion of the potential client population and the acknowledged importance of educational attainment. Furthermore, schools are the only extra-familial agency with legally mandated responsibility for adolescents. They are explicitly prohibited from excluding or otherwise discriminating against pregnant students. Yet, this study demonstrates the resistance of mid-level (primarily male) school officials to school-based services, the effectiveness of opposition groups in blocking them, and a tendency to use the programs as a de facto mechanism of exclusion from the regular school program.

Determinants of Program Success

As dicussed in Chapter 8, we found several pre-existing conditions associated with successful program development. These included a strong, responsive voluntary sector, local and flexible funding to supplement state and federal aid, resources and mechanisms for coordination, elite support and sanction, and administrative and political leadership. These conditions are not randomly distributed. They tend to be clustered in certain states and communities, some with greater than average affluence. This suggests a distressing bias in the distribution of services: the more resource-rich,

better-served communities are those most likely to be able to overcome the obstacles and develop comprehensive programs. Localities lacking the requisite resources and capacity are less likely to develop programs.

A number of political and administrative strategies are invoked in the quest for program support. Influential backers, predominantly male, are enlisted. The issue of adolescent pregnancy is attached to other concerns in an effort to find new resources and broaden the base of political support. Legitimation is also sought through an emphasis on the medical aspects of services. However, program advocates conceal much of what they are doing for fear of jeopardizing gains already made. This pervasive strategy of concealment, while necessary, undermines the provision of services and limits their scope and reach. It is difficult to imagine that much progress can be made in developing, supporting and maintaining services without fundamental changes in the attitudes of those who control the resources.

We observed that state policies, backed with program funds, are a crucial determinant of program development. Massachusetts funds special programs through a competitive grant process; Michigan and California provide basic support through the schools, and award additional funds on a competitive basis. Tennessee, like many of the poorer states, provides no such assistance. Our findings confirm what others have noted about competitive, discretionary grants. They tend to be awarded to localities that in some ways need them the least: the ones with the requisite resources to develop a viable plan. And once awarded, the only way additional localities can be added without increasing state or federal aid is by defunding existing programs, hardly a comforting prospect. The competitive discretionary grant process reinforces tendencies to skew services to the more affluent and capable communities.

Federal programs play a key role. Particularly important are Title XIX of the Social Security Act (Medicaid) that pays for much of the health services; Title XX of the Social Security Act that supports social services, and to a lesser extent, day care; Maternal and Child Health Services block grant funds (Title V of the Social Security Act); General Revenue Sharing; Title I (now Chapter 1) of the Elementary and Secondary Education Act; and Titles X (family planning) and XX (Adolescent Family Life) of the Public Health Services Act. Local managers show great ingenuity in piecing together programs with these and a variety of other resources--for special and vocational education, job training, Head Start,

and until they were discontinued, CETA, Model Cities and anti-poverty program funds. However, those funding sources that remain are stretched very thin and adolescent pregnancy programs are at a decided disadvantage in competing for support from them. At this time, they are all slated for further substantial reductions.

Limitations of the Comprehensive Services Model

This study shows how truly exceptional are those localities that have developed comprehensive programs. Even the best programs are limited in the numbers reached, services provided and duration of contact. As public policy, the comprehensive services model is perhaps better suited to political compromise and symbolism than effective problem solving. The model is based on faulty assumptions: that the appropriate services exist and need only be administratively linked together; that localities have the capability and resources to mount and maintain such programs with minimal state and federal assistance; and that the problematic aspects of adolescent pregnancy and parenthood are best addressed through services. A national policy that seeks to address the problems associated with unintended adolescent pregnancies by encouraging the development of some or even many such comprehensive programs will necessarily have limited effect.

The terminology: comprehensive, model, coordination and linkages; the encouragement of local initiative; and the strategy of offering demonstration grants to a few localities reflect the social welfare traditions of the late 1960s and 70s. Services are designed to change and control individual behavior; the social conditions that underly such behavior and its consequences are largely ignored. The problem is defined as residing within the individual, in this instance, the "bad girl." Services are residual and limited in time, scope, and adequacy. Institutional deficits, including the lack of adequate health care, subsistence, education and employment opportunities, housing and day care are ignored. Ultimate responsibility for addressing the problem is relegated to localities that are ill-equipped to assume the burden. The few successes, the exemplary programs, are cited as evidence of the efficacy of the overall approach, while the unusual circumstances that set such programs apart are overlooked.

An alternative to this residual approach is an improved welfare state along the lines that characterize most other advanced industrial nations. Such welfare state programs offer free, accessible health care with strong incentives to

pregnant women to use them. They provide income support and housing assistance for those needing it. They offer universal, liberal maternity leave policies, day care services, special housing, employment, and social services to help young people during the difficult transition from childhood to adulthood.[1] Most important is preparation for responsible sexuality and parenthood, for males as well as females.[2]

RECOMMENDATIONS

Current federal policies foster a paradoxical and in some ways cruel approach to adolescent parents. There is no national sanction or policy for sex education. Family planning activities, especially for adolescents, are limited both in level of support and in the aggressiveness of their promotion. Yet adolescents are blamed for getting pregnant, and when they do, there are limited services available to help them. Thus, while the political debates rage, the unfortunate youngsters get the worst of both policy alternatives: insufficient preparation for sexuality, and inadequate assistance with childbirth and parenthood. Leadership is needed at the national level to support both services for pregnant and parenting adolescents as well as what most Americans say they want: publicly financed sex education for their children and easily available contraception.[3] Such leadership at the national level is sorely needed to combat the punitive attitudes that currently prevail, particularly among the male gatekeepers who control the requisite resources and institutions. The social responses to adolescent pregnancy illustrate the subtle but powerful consequences of male domination of the public and private institutions of society. In this regard, one may be encouraged by the movement of women into positions of power, while recognizing how much remains to be done.

We do not expect drastic policy changes to occur very soon. We mention them in the belief that current efforts are best assessed against the benchmark of what enlightened policies might achieve. It is important to fully comprehend the limits of what may be expected under present arrangements. Even within such limitations, there is much that can be done to improve and expand services. However, even incremental changes require money. The development of programs and services is constrained by inadequate funds and punitive attitudes toward young unmarried women who become pregnant. The approaches suggested below, while perhaps out of step with current deficit reduction priorities, are well

within the normal politics of incremental program development. Without action on these rather modest initiatives, it can only be concluded that this nation's policy toward children who become parents is one of neglect.

Strengthening Existing Federal Programs

Local services are built around and dependent upon a number of federal programs that support key health, welfare, and social service activities. These include Title XIX (Medicaid), Title XX (social services), Chapter 1 (Elementary and Secondary Education Act), and federal nutrition, family planning and maternal and child health programs. Most important are health services, particularly for low-income women and their children. These programs need to be strengthened and funded at more adequate levels. Approaches that encourage additional claimants on already inadequate resources will succeed only in engendering greater conflicts among service providers.

Supporting state efforts. Rather than making a few token grant awards to individual localities, federal policy would achieve much more by fostering state involvement. State policies and funds are probably the most important spurs to program development. Incentive grants to states, based on some measure of need and capacity, together with technical assistance, could foster the development of programs in regions of the country that are otherwise unlikely to be able to afford them. A grant program of several hundred million dollars could yield an immediate burgeoning of local services, particularly in unserved and underserved areas.

We concur with the recommendations of the National Association of State Boards of Education (NASBE) that state education and social service agencies should: "maintain a permanent interagency committee" to assess the nature of the problem, develop interagency agreements and seek funding; designate staff to promote policies and develop services; collect data on the target population and evaluate program outcomes; develop and promote appropriate health services, sex and parenthood education, job training and placement services; and give priority to adolescent parents for Title XX infant and child day care.[4]

Support for planning and coordination. Localities that need services the most are often the least able to mount the effort even to apply for available program funds. Federal and state policy should encourage local planning and

coordination for comprehensive service programs by making small planning grant awards to local agencies or collaborative groups. Such planning grants should be viewed as an initial step in service development, only to be undertaken if program support funds are available. Existing grant programs should take cognizance of the need to provide funds for coordination. State technical assistance personnel and loaned staff from successful programs could also help in program planning and development.

Incentives for the development of school-based models. While reason suggests the schools as the logical focus of service development, the practicalities of school governance inhibit their involvement despite federal anti-discrimination legislation (Title IX).[5] Mid-level staff, usually principals, often seek to exclude pregnant students, and are pleased to be able to send them to a separate program. Public school culture and tradition militate against activities that fall outside the realm of academic instruction. Administrators seek to avoid controversial issues. Yet, all these barriers can be overcome, as they have been in some schools. Schools have undertaken many activities that fall outside the normal curriculum: education of handicapped students, special enrichment and nutrition programs for the poor and educationally disadvantaged, vocational and adult education, to mention only a few. The key to such departures from tradition is twofold: money and law. Schools are required by law to undertake such responsibilities, and are provided additional funds for doing so. While schools may not now legally discriminate against or exclude students because of pregnancy, many continue to do so informally, and they are unlikely to face challenge. There is no positive legal mandate to serve pregnant students. Funds for program support for pregnant and parenting adolescents, over and above the normal per pupil allotment, must usually be taken from other competing and worthy activities. On the other hand, even the average daily attendance (ADA) reimbursements, limited as they are, offer incentives for retaining pregnant students. The incentives would be much stronger with more adequate reimbursement. A federal (or state) initiative offering adequate financial support for school-based programs and penalties for failing to provide for the educational needs of pregnant students would generate new program development in the schools, and would help shift the climate of professional school opinion in a more favorable direction.[6] An important component of such programs is infant day care which requires additional federal and state support. Support should also include training funds for school personnel similar

to the approach followed under programs for educating the handicapped.

Public welfare services for adolescents. One local effort we observed, the REAP program (Resources and Education for Adolescent Parents) in Fresno, could serve as a model for state and local public welfare agencies. In this instance, the local office of the department of social services established a special adolescent unit staffed by workers specially trained to help young clients. They reduced the waiting time and red tape involved in processing AFDC and Medicaid applications and maintained a wide referral network to secure medical, housing, child care, and other kinds of assistance. Such priority treatment was deemed necessary because of the special needs of adolescents, the importance of getting them linked with medical services and helping with transitions back to school, into a job or job training, or into independent living arrangements. This particular unit seemed to work well because of the energy and commitment of its supervisor and staff, all of whom volunteered for the assignment. However, to institutionalize such special programs would require extra funds. Otherwise, already overworked welfare staff might simply find new duties added to their current large workloads.

Adolescence and Public Policy

Comprehensive service programs, despite their many apparent virtues, are not the magic bullets that will solve the problems associated with unintended teenage pregnancy and parenthood.[7] Nor should they be expected to do so. As short-term emergency measures, they should be assessed according to criteria appropriate for crisis intervention, which is what they provide, with few exceptions. We believe that adolescent pregnancy must be addressed by a broader range of policies intended to facilitate the transition from childhood to adulthood, especially for those suffering the effects of poverty and limited opportunity. Such policies would seek to provide adequate education, vocational training, and meaningful work as well as day care and health services. Even more basic is the need to combat the sexism and racism that limit the alternatives available to many of today's youth. Patchwork programs are an inadequate substitute for fundamental reform.

NOTES

1. Peter Flora and Arnold J. Heidenheimer (Eds). The development of welfare states in Europe and North America. New Brunswick, NJ: Transaction, Inc., 1981; Alfred J. Kahn and Sheila Kamerman. Child care programs in nine countries. DHEW Publication No. (OHD) 30080, no date; Sheila B. Kamerman and Alfred J. Kahn. Child care, family benefits, and working parents: A study in comparative policy. New York: Columbia University Press, 1981.

2. P. Brown. The Swedish approach to sex education and adolescent pregnancy: Some impressions. Family Planning Perspectives, 1983, 15:90; Birgitta Linner. Sex and society in Sweden. New York: Random House, 1967, 1972; E. Ketting. Contraception and fertility in the Netherlands. Family Planning Perspectives, 1983, 15:19; Charles F. Westoff, Gerard Calot, and Andrew D. Foster. Teenage fertility in developed nations: 1971-1980. Family Planning Perspectives, May/June, 1983, 15(3):105-110.

3. Alan Guttmacher Institute. School sex education in policy and practice. Issues in Brief, February 1983, 3:1; Sol Gordon, Peter Scales, and Kathleen Everly. The sexual adolescent: Communicating with teenagers about sex. Scituate, MA: Duxbury Press, 1979, p. 9.

4. Sharon J. Alexander. A report of the Adolescent Parenthood Project. Washington, D.C.: National Association of State Boards of Education, 1980.

5. See Gail Zelman. The response of schools to teenage pregnancy and parenthood. R-2759-NIE. Santa Monica, CA: The Rand Corporation, 1981.

6. For example, the Massachusetts Department of Social Services sought to encourage school-based programs in their request for proposals.

7. For a recent assessment of local programs, see Martha R. Burt et al. Helping pregnant adolescents: Outcomes and costs of social delivery: Final report on the evaluation of adolescent pregnancy programs. Washington, D.C.: The Urban Institute, February 1984.